IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8835

June 27, 2006

Donna Nelson, Administrator
Sunbridge Care & Rehabilitation for Payette
1019 3rd Avenue South
Payette, ID 83661

Provider #: 135015

Dear Ms. Nelson:

On **June 16, 2006**, a Recertification survey was conducted at Sunbridge Care & Rehabilitation for Payette by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 10, 2006**. Failure to submit an acceptable PoC by **July 10, 2006**, may result in the imposition of civil monetary penalties by **July 31, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 21, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 21, 2006**. A change in the seriousness of the deficiencies on **July 21, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 21, 2006** includes the following:

Denial of payment for new admissions effective **September 16, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 16, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 16, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 10, 2006**. If your request for informal dispute resolution is received after **July 10, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135015	A. BUILDING _____ B. WING _____	06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNBRIDGE REHAB FOR PAYETTE	1019 3RD AVE S PAYETTE, ID 83661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification at the facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Barbara Franek, RN Diane Green, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Sunbridge Rehab for Payette does not admit that the deficiencies listed on the HCFA 2567L exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts and conclusions that form the basis for each deficiency."	
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview and review of resident council minutes it was determined the facility did not ensure resolution of grievances for 3 of 3 residents who attended a group meeting with surveyors. Findings include: 1. During the entrance conference on 6/12/06 at	F 166	**F166 Grievances** 1. No specific residents were identified 2. All residents have the potential to be affected An informal resident council, (with no elected officers) will meet monthly to voice grievances. Staff will document all resident grievances outside of informal resident council on Complaint/Grievance form and will be turned into Administrator. Grievances will be given to appropriate departments for resolution. 3. Informal Resident Council will review prior month grievances to ensure resolution. Individual	

RECEIVED
JUL 10 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronna Nelson	Administrator	7-8-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 11:45 am, the administrator stated that the facility did not have a formal resident council. She indicated the residents had no interest in having a formal council and no one wanted to act as an elected officer for the group. However, later documentation on "Resident Council Minutes" forms was provided. They contained the following documentation: a.) March 1, 2006- "...around 8:00 pm the east nursing station gets noisy...need to keep it down...Late at night there are res[idents] calling out for help takes awhile for someone to come... [room number identified] stated that there was an odor in her room..." The room number was on the 300 hallway. b.) April 14, 2006- "Resident's would like to have tacos sometimes. Menus seem to be the same all the time. Would like to go to the library and check out lg [large] print books. Would like to go out side when weather gets better (walks) and would like more bingo. Act [Activity] staff holds Bingo 3 x wk [week]." c.) May 22, 2006- "...Checked into getting a small library started in the facility of lg [large] print books." 2. A group meeting was held on 6/13/06 at 10:30 am, with three residents in attendance. The residents had the following concerns regarding life in the facility: a.) There was too much repetition on the menu of chicken and turkey items. In addition to concerns of too much poultry, they stated, "we are served whole pieces of chicken they are always thigh pieces and sometimes are very small." b.) The nurses' station on the east hall gets very noisy at night. Especially when they start laughing out there. There are some men on the hall that	F 166	grievances will be discussed with individual resident with plan of resolution. 4. Informal Resident Council minutes will be reviewed monthly. Resident interviews will be conducted by Social Service Designee to assure that all resident grievances are resolved. All grievances will be reported to the Continuous Quality Improvement Committee and will be followed until resolved 5. Date completed 7/21/06	

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F 166	Continued From page 2 call out at night very loudly. The 300 hall has odors of urine and feces. One resident stated a request for air freshener had been made because odors get so bad in her room. She indicated the air freshener had helped. c.) The activities were sparse. Not enough for residents to do during the day. The residents in attendance were asked if they wanted to have a resident council with officers. They stated they did not want one and none of the residents wanted to be officers of the council. Please refer to F248 for additional findings regarding activities. Refer to F253 for findings related to odors in the 300 hall. Refer to 364 for findings related to repetition of menu items and other food related issues. 3. On 6/16/06 at 8:30 am, the DON was interviewed. She stated that the facility did not have a formal resident council. However, as part of the Quality Assurance Committee plan they had decided to seat individuals who would have been able to participate together for dining. They then documented concerns brought up by residents during the dining. The concerns were documented on the Resident Council Meeting forms.	F 166		

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F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	**F225 Staff Treatment of Residents** 1. Identified residents #1-#3-#4-#7-#8-#10 medical records were reviewed for appropriate interventions to prevent falls or injuries. Care plans were updated as appropriate 2. Any resident that has an injury or fall will have it reported through incident and accident reports, with a through investigation being completed 3. In- service L.N. (Licensed Nurses) and IDT (Interdisciplinary team) on reporting guidelines, and investigation procedures for incidents and accidents. 4. IDT (Interdisciplinary team) to audit post incidents and accidents for completeness of investigation and appropriate preventions to prevent reoccurrence. .Administrator will monitor incidents and accidents for appropriate investigations as processed. Audits/Monitor results will be reported monthly to Continuous Quality Improvement committee, and will be followed until issue resolved. 5. Date of Completion: 7/21/06	

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F 225	Continued From page 4 by: Based on record review and staff interviews, it was determined the facility did not complete thorough investigations to rule out abuse or neglect and investigation reports were not properly signed and dated to ensure the incidents had been reported to the administrator as required. This affected 6 of 11 (#1, 3, 4, 7, 8, &10) sampled residents who were reviewed for incident and accidents. The findings include: 1. Resident #4 was admitted to the facility on 1/30/06 with diagnoses of cerebral vascular accident (CVA) with resolving hemiplegia, hypertension, hypothyroidism, kyphoscoliosis, osteoarthritis and depression. The initial MDS, dated 2/5/06, documented the resident with modified cognitive impairment (some difficulty in new situations only). There were no falls documented for this assessment. The most current quarterly MDS, dated 4/25/06, documented the resident had fallen in the last 30 days and she needed limited assistance for transfers. The same MDS also documented her cognition as moderately impaired (decisions poor; cues/supervision required) which was a decline. The following event reports were documented for resident #4: 2/2/06, 10:15 pm- "...Staff passing this room noted this resident was sitting on the floor. She stated that she was getting up to take her pills. There was no injury noted. ...Interventions Implemented... An alarm has been placed on her bed and wheelchair. Staff has been inserviced regarding her alarms. The administrator signed but did not date when the event report was	F 225		

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F 225	Continued From page 5 reviewed. 2/10/06, 4:00 am- "Staff responded to her bed alarm. The resident was sitting up on the edge of the bed. She slid to the floor gently. There was no injury noted. ...Interventions Implemented... This resident has a bed alarm. We will place a non-skid mat at her bedside." There was no indication the staff had investigated what the resident needed or if she had used her call light prior to trying to get up. The administrator signed the report but did not date when it was reviewed. 2/18/06, 11:00 am- "No injury... This resident forgot that she cannot ambulate without assistance and attempted to self-transfer and sat down on the w/c [wheelchair] foot pedals, and then slid to the floor. ...Interventions Implemented... Staff inservicing done. Resident has tab alarms on her w/c and pressure alarms on her bed." There was no indication if alarm had sounded. What was the resident trying to do? When was the last time staff had assisted her? The administrator signed the report but did not date when it was reviewed. 3/11/06, 2:30 am- "No injury... Staff entered room, responding to bed alarm. This resident was sitting on the floor. She stated that she was going to the bathroom. CNA was in the room just a few minutes prior asking if she needed anything and the resident stated that she did not need anything. ...Interventions Implemented... We have added a tab alarm. We will cont. [continue] to enourage [sic] her to use her call-light and wait for assistance." This report was not signed or dated by the administrator. 3/12/06, 10:30 am- "Staff responding to alarms sounding, found this resident sitting on the floor. She stated that she was going to the bathroom. CNA had been in the room only a few minutes	F 225		

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F 225	Continued From page 6 before and offered to assist her, but the resident had denied needing her for anything. Resident denies any injury and there were none noted with assessment by LN. ...Interventions Implemented... Her alarms have been changed out. (Not investigated to determine why alarms were changed out when they were sounding per initial report). Staff are monitoring her frequently. She has been placed on a toileting schedule." There was no signature or date by the administrator indicating the report had been reviewed in 5 working days. 3/20/06, 4:45 pm- "...heard a noise and entered the res. room. He found the resident sitting on the floor. She denied any injury and none were noted with assessment. ...Interventions Implemented... The alarm on her bed was changed out. This resident has been started on abx [antibiotics] for a UTI." There was no indication the facility had determined why her alarm did not sound or which alarm did not sound. It was not clear if she had gotten out of bed or her wheel chair. There was no signature or date by the Administrator indicating the report had been reviewed in 5 working days. 4/20/06, 4:45 pm- "Staff responded to alarms sounding and found resident sitting on the floor in front of her wheelchair. She stated that she had no injuries and none were noted, until a bruise was found 24 hours after her fall on her left buttock. ...Interventions Implemented... This resident has poor safety awareness. She has alarms in place and is checked on frequently. She had non-skid footwear on. We will continue to monitor her closely." The report was signed by the Administrator but not dated. 5/3/06, 11:45 am- "Staff responded to alarm sounding, found resident on the floor at her	F 225		

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F 225	Continued From page 7	F 225		

bedside. She had attempted to self transfer. She stated that she had no injury, and there were none found with assessment. ...Interventions Implemented... Resident education done, staff did frequent monitoring throughout the day. She has alarms on both her bed and wheelchair." The report did not indicate which alarm was sounding. Was the resident getting out of her bed or her wheel chair? What did she need? When had staff last assisted her? The report was signed but not dated by the administrator.

In addition to the event reports the following documentation was in the resident's record:
A physician progress note, dated 2/24/06 documented, "I was asked to see her today because her lt [left] hand and fingers are all black and blue as though she has had some trauma. The occupational therapist that is working with her states that has occurred just since yesterday. She does not recall any injury to it but she apparently has some dysfunction of the lt hand. it has some 'athetoid movements' that she states just does on its own and certainly may have gotten in to the wheelchair at some time if she had some uncontrolled movements...Injury to lt hand resulting in ecchymoses and mild abrasions...Reassured that if we can protect that lt hand the discoloration, swelling, etc. will clear..."
On 4/21/06 another physician progress note documented, "...Today she demonstrates that she can grip pretty well with her lt hand. The last time I saw her she had fallen and bruised it quite badly and most of the discoloration has cleared..."
The DON was asked for the event report/investigation done for this incident. On 6/15/06 at 1:30 pm, she told the surveyor that no event report was documented. The facility did not

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F 225	Continued From page 8 rule out abuse. A nurse progress note, dated 4/9/05 (5:00 am) documented, "Resident alert, able to make needs known- [illegible] pain meds effective- No c/o pain/discomfort, daughter in to visit at HS [night time]- while here resident caught left thumb in w/c staff removed from catch with difficulty- no bruising noted at time to thumb or hand but did discuss possibility of bruising with daughter due to ease of bruising on affected side- resident has been resting quietly in bed, up to toilet with assist, alarms in place to notify staff of attempts to self transfer." There was no thorough investigation for this incident to rule out abuse or neglect. Nor was there a corresponding event report. 2. Resident #1 was originally admitted to the facility on 1/12/06 and readmitted on 2/01/06 and 5/02/06, with diagnoses of pneumonia, colitis with Clostridium difficile, and failure to thrive. The "Fall Risk Assessment," indicated the resident had been assessed as being at high risk for falls since the initial assessment of 1/12/06. A total score of 10 or above was considered to be an indicator of a high risk for falls. The resident had the following scores: 1. 1/12/06 - 22. 2. 2/01/06 - 18. 3. 4/28/06 - 11. 4. 5/02/06 - 18. 5. 6/06/06 - 12. The MDS with the assessment date of 1/18/06, indicated the resident had a short term memory loss problem, required limited assistance of 1 person for transfer and walking and was not able	F 225		

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to be tested for standing balance without physical help.

The most recent MDS with the assessment date of 5/08/06, indicated the resident had fallen in the past 30 days and also in the past 31 to 180 day period of time. The primary mode of locomotion was a wheelchair and the resident was not able to be tested for standing or sitting balance without physical help. The MDS indicated the resident had a problem with short term memory.

Review of the care plan conference summary dated 1/16/06, indicated that alarms had been placed on the bed and wheelchair. The care plan dated 5/29/06, indicated the resident had an alarm applied to the bed on 5/02/06, the date of the last readmission.

The "Event Management System," was reviewed and the following accidents had been identified:

A. 4/28/06 at 3:20 am - The incident/accident investigation (I/A) indicated the resident was getting up to the toilet and fell sustaining an abrasion to the left elbow. The resident was able to tell the staff he was going to the bathroom. The I/A did not indicate if the call light was handy or if the resident was having difficulties with incontinence issues. There was no mention of an alarm being in place and the care plan indicated alarms were used in the bed and chair. This I/A was signed by the administrator but there was no date to indicate when the administrator had signed the report.
B. 4/28/06 at 4:35 am - The I/A indicated the resident was found on the floor wrapped in the bedding. The resident had stated he was trying to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 get some water. While being assisted up by staff, the resident hit his head on the dresser and sustained a skin tear. This second fall occurred 75 minutes after the first fall. The I/A did not indicate whether or not a decline in medical status was occurring or if incontinence was playing a part in the falls. There was no mention of an alarm being used and if so, did it sound to alert staff? This I/A was signed but not dated by the administrator. Review of the nursing notes indicated the resident had been complaining of stomach cramps since 4/11/06 and was on a titrating dose of antibiotic for the colitis. The following nursing notes indicated the resident was having increased loose stools on 4/28/06: a. 4/28/06 at 2:35 am - "Resident alert. No c/o [complaints of] stomach 'pain' but has had 3 loose stools. PRN [as needed] Imodium given as ordered. Temp. 98.1. PRN pain meds at HS [night time]." b. 4/28/06 - "Condition Change Form...Resident had loose stools on PM [evening] shift. PRN med given. Continued to get up to toilet. At 0320 [3:20 am] resident fell in room. Only injury noted is an abrasion to left elbow..." c. 4/28/06 - "Condition Change Form...At 0435 [4:35 am] resident turned over in bed and fell out of bed onto the floor. No injury until he hit his head on the dresser drawer handle when staff started to help him up..." d. 4/28/06 at 1030 [10:30 am] - "Res [resident] B/P [blood pressure] [down] 88/56. HR [heart rate] [elevated] 117 - 120. SpO2 [oxygen saturation level] [down] 88.1% RA [room air]. [low] grade fever 100.1...diarrhea x 2...pt [patient] will	F 225		

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be transported to VAMC [Veterans Administration Medical Center]..."

The resident, who was at high risk for falls and was having loose stools and subsequently had to be transferred to a hospital, had 2 falls over a 75 minute period of time. Neither the I/A investigations nor the nursing notes addressed the possibility there was a connection between the falls and the frequency of the loose stools and subsequent medical decline resulting in transfer to a hospital.

I/A's continued:

C. 5/02/06 at 8:46 pm - The I/A indicated the resident was found on the floor, next to the bed. The summary stated, "He had been restless earlier." This I/A was signed but not dated by the administrator.

The nursing notes indicated the resident had returned to the facility from the hospital on 5/02/06 at 6:00 pm, from the hospital. The resident was unable to sit upright and was on an air mattress. The "Condition Change Form," for 5/02/06 at 8:46 pm, stated, "At 2046 [8:46 pm] this evening, resident rolled out of bed onto the floor. No apparent injury noted at this time...put siderails on bed to assist with bed mobility and to define edge of bed and put a mattress on floor at bedside..."

Neither the nursing notes nor the I/A indicated whether the resident was able to state the reason for the fall. Since the resident was found after the staff heard a noise, there were no staff interviews concerning an unwitnessed fall or further

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investigation to rule out abuse and the reason for the fall. The nursing notes and the I/A did not mention if alarms were in use and if so did they alarm. The care plan did indicate that an alarm had been applied to the bed on 5/02/06. The nursing notes and I/A did not mention if the call light was handy and if the resident was alert enough to use it.

D. 5/06/06 at 6:00 pm - The I/A indicated the resident was found on the floor next to his recliner. The resident was calling out for assistance. The call light was lying across the recliner arm. This I/A was signed but not dated by the administrator.

The "Condition Change Form," in the nursing notes, stated, "Resident slid from recliner chair to the floor @ 1800 [6:00 pm] and was found sitting on the floor by recliner. Calling 'help, help.' No apparent injury and was assessed..." The note was dated 5/06/06.

Neither the nursing note or the I/A mentioned if the fall was witnessed or not. If unwitnessed, there was no documentation the resident was interviewed and able to explain the fall. If witnessed by staff, there was no documentation of staff seeing the resident sliding from the recliner to the floor.

3. Resident #10 was admitted to the facility on 1/22/06 and readmitted on 2/16/06 with diagnoses of Alzheimer dementia, anxiety disorder and chronic obstructive pulmonary disease.

The "Fall Risk Assessment," indicated the

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F 225	Continued From page 13 resident had been assessed as being at high risk for falls since the initial assessment of 1/22/06. A total score of 10 or above was considered to be an indicator of a high risk for falls. The resident had the following scores: 1. 1/22/06 - 16. 2. 2/16/06 - 14. 3. 5/15/06 - 14. 4. 5/30/06 - 16. The admission MDS assessment for the assessment date of 1/28/06, indicated the resident had both long and short term memory problems, was moderately impaired with cognitive skills for daily decision making, required limited assist with transfers, and required 1 person assist for walking. The quarterly MDS for the assessment date of 5/13/06, indicated the resident still had both long and short term memory problems, was moderately impaired with cognitive skills for daily decision making, required 1 person assist with transfers and walking, and had fallen in the past 31 to 180 days. The initial care plan dated 1/26/06, indicated the resident had stand by assistance with transfers and ambulation and was receiving physical therapy to improve gait and balance. The care plan dated 6/05/06, indicated the approaches to prevent injury from falls included, encouraging the resident to request assistance, pressure alarm to the bed, self releasing, alarming, seatbelt to the wheelchair, and the need to evaluate the resident for a toileting program.	F 225		

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F 225	Continued From page 14 The "Event Management System," was reviewed and the following accidents had been identified: A. 1/31/06 at 8:00 pm - The incident/accident investigation [I/A] indicated staff responded to the sound of an alarm and the resident was found sitting on the floor, next to the wheelchair. This I/A was signed but not dated by the administrator. The "Condition Change Form," in the nursing notes stated, "Res [resident] slid out of w/c [wheelchair] while in hall onto buttocks. Denies pain/discomfort. No apparent injuries." The note was dated 1/31/06. Neither the nursing notes nor the I/A indicated if the fall was witnessed or if the resident, staff, or other residents were interviewed to rule out abuse or neglect. Neither the nursing notes nor the I/A indicated where the fall had occurred and whether or not the resident was trying to complete some type of activity of daily living such as toileting, turning on a TV, or pouring a glass of water. B. 5/04/06 at 7:30 pm - The I/A indicated alarms sounded and the resident was found sitting on the floor next to the wheelchair. This I/A was not signed or dated by the administrator. The "Condition Change Form," dated 5/04/06, indicated the resident was found sitting on the floor next to the bed. Neither the nursing notes or the I/A indicated the resident had been interviewed concerning the fall except to document the resident denied any pain. There was no documentation to answer why the resident fell. Was the resident trying to transfer	F 225		

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F 225	Continued From page 15 back to bed? When had the resident last been checked? C. 5/27/06 at 12:00 pm - The I/A indicated alarms sounded and the resident was found sitting on the floor next to the wheelchair. The I/A indicated the resident was in the doorway of her room. The intervention indicated the resident had started treatment for a UTI [urinary tract infection]. This I/A was signed but not dated by the administrator. The nursing notes for 5/27/06, did not have any additional information to add to the fall investigation. Neither the nursing notes nor the I/A indicated if the fall was witnessed or if the resident was able to state why she fell. For instance, was the resident having frequent urination and trying to get to the bathroom? D. 5/30/06 at 4:00 pm - The I/A indicated the resident was trying to self transfer out of the wheelchair and ended up on the floor. The intervention indicated the antibiotic treatment for the UTI was continuing. This I/A was signed but not dated by the administrator. E. 5/30/06 at 4:30 pm - The I/A indicated the resident was fidgeting in the wheelchair and attempting to self-ambulate. The resident fell out of the wheelchair and sustained a cut above the right eye. The intervention indicated another urine sample was sent to the lab and the antibiotic therapy for the previously diagnosed UTI was continuing. This I/A was signed but not dated by the administrator. The nursing notes for 5/30/06 did not have any	F 225		

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additional information to add to the fall investigation.

The same investigational questions remained unanswered. Was the fall witnessed? Why was the resident falling? Was the resident complaining of dysuria and/or frequent urination?

On 6/15/06 from 2:50 to 3:20 pm, the DON, administrator and nurse consultant were interviewed concerning the fall investigations and prevention for falls. The DON concurred that more could have been done to improve prevention as well as investigation.

4. Resident #7 was originally admitted to the facility on 9/10/05 and re-admitted 1/07/06 and again on 5/01/06. The resident's diagnoses included status post cerebral vascular accident and gastro-intestinal bleeding.

The "Fall Risk Assessment," indicated the resident had been assessed as being at high risk for falls since the initial assessment of 9/10/05. A total score of 10 or above was considered to be an indicator of a high risk for falls. The resident had the following scores:
1. 9/10/05 - 12.
2. 10/16/05 - 14.
3. 11/16/05 - 14.
4. 12/26/05 - 15.
5. 5/02/06 - 20.

The care plan dated 9/10/05, indicated the resident had been identified as being at risk for falls and had chair, bed and motion alarms in place. On 10/03/05, the care plan was updated to include a seat belt for the wheelchair for safety

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F 225	Continued From page 17 and lack of trunk control. The "Event Management System," was reviewed and the following accident had been identified: A. 12/30/05 at 1:30 pm - The I/A stated, "This resident has had a CVA [cerebral vascular accident]. He has no safety awareness. He was sitting in his wheelchair next to his bed a few minutes before he was found next to his bed, with his wheelchair tipped over on it's side. There were no apparent injuries noted with assessment. He does reach over and grab his side rail on his bed. It appears that is what happened. We have adjusted his care plan to ensure that he is not left unattended in him room in his wheelchair." The intervention on the I/A stated, "The staff have been inserviced and his care plan has been updated so that he is not left alone in his room while he is in his wheelchair." This I/A was not signed or dated by the administrator. The corresponding "Condition Change Form," in the nursing notes, dated 12/31/06 at 2:45 pm, stated, "Dr. [name of physician] - pt [patient] attempted self transfer (safety belt in place) by using bed rail to use for grab bar. Turned w/c over on top of self. No apparent injury..." Neither the nursing notes nor the I/A indicated whether the resident had been interviewed or was able to communicate in order to reach the conclusion that the wheelchair was turned over because the resident tried to use a side rail as a grab bar. The nursing notes and the I/A both give the impression the fall was unwitnessed but if so, that point was not clearly identified in the investigation. Neither the nursing note nor the I/A	F 225		

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F 225	Continued From page 18 indicated whether or not staff responded because alarms were sounding. The DON, administrator, and nurse consultant, were interviewed on 6/15/06 from 2:50 to 3:20 pm. The DON stated the alarms did go off when the wheelchair tipped over. The DON stated, "You could hear it all over." When a surveyor mentioned that information such as alarms in use and/or sounding would be good information to have on an accident investigation form, the DON stated, "Yes it would." In addition to the above, out of 10 I/A reports, the administrator had signed 8 without dating them and 2 had not been signed or dated by the administrator. 5. Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA. The initial MDS, dated 11/17/05, did not indicate the resident had recent falls. A RAP did trigger for falls and the following was documented: "Rap triggered R/T [related to] recent CVA [decreased] mobility contribute to his decline and risk in safety issues. He is equipped [with] a safety alarm on his chair to alert staff of his status..." His most recent quarterly MDS, dated 5/1/06, documented he had fallen in the last 30 days and in the last 31-180 days. An additional fall risk assessment, dated 3/25/06, documented a score of 15 for fall risk. (Scores of 10 or above = high risk). Event reports were reviewed for resident #8 and contained the following documentation regarding	F 225		

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non injury falls:
12/4/06, 10:00 am- "This resident was found sitting on the floor next to the toilet with his pants pulled partially down. His wheelchair was at the door of the bathroom. It appears he was self-transferring... Interventions implemented, We have placed a tab alarm to attach to his wheelchair. We have done resident education to have [resident #8] use his call-light and wait for assistance. He has agreed to do so." The facility did not thoroughly investigate. There was no indication that staff or resident was interviewed to determine when he was last toileted, had he used a call light?
12/13/05, 6:30 pm- "Resident self-transferred from wheelchair to bed. He slid off the edge of the bed to the floor...Interventions implemented, This resident is non-compliant with waiting for assistance. We are setting up a care conference with him and family. We have placed a self-releasing alarming seat belt on his wheelchair and have done education with him again regarding using his call-light and waiting for assistance. He states he understands and that he will use the call-light and wait for assistance. The report was not signed as reviewed by the Administrator. The report did not indicate if interviews were done to determine how long the resident had been waiting for assistance. There was no indication as to whether the call light had been used by the resident. The report indicated the resident had side rails at the time of the fall. There was no information documenting if the side rails were up at the time he fell.
1/23/06, 3:40 pm- "Resident was found on the floor on his hands and knees. He was attempting to get back into the bed. He had taken off his bed alarm, and stated that he was going to the

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bathroom. Interventions implemented, Ongoing resident education is needed in this situation. We are also evaluating this resident for a toileting schedule." The facility was again providing education but not investigating why the resident was going to the bathroom without assistance. The resident had been in the facility since 11/1/05. There was no indication of why a toileting schedule had not been established. Please refer to F315 as it relates to findings of inadequate assessment and toileting patterns which were not established for this resident. The report was signed by the Administrator but no date of review was recorded.
1/24/06, 5:50 am- "Resident was found on the floor. He indicated he was trying to self-ambulate. He had his alarms disconnected. Interventions implemented, Staff education done to check on all alarms. Resident continued education regarding using call-lights and waiting for assistance. The facility did not interview staff working with the resident nor determine why the resident had been trying to ambulate independently. The report indicated he had the alarms disconnected but the documentation did not determined whether or not staff may have forgotten to connect the alarms or if he stated he did it himself. The report was signed by the administrator but not dated.
3/25/06, 7:00 pm- "LN heard the res. turn on the call light in the bathroom. The CNA went right into the room and found the resident sitting on the floor. He had removed his tab alarm. Interventions implemented, Went with an interrepter [sic] to [resident #8] and discussed the need for him to use the call-light and wait for assistance. He acknowledged that he needs to wait for help. He also stated that he understands

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F 225	Continued From page 21 English very well." There were no staff and resident interviews concerning the unwitnessed fall. The facility had not determined what the resident's toileting needs were. The report was not signed (as reviewed) by the Administrator. 6. Resident #3 had similar findings of investigations not complete.	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined that 5 of 10 sample residents (#'s 2, 3, 5, 6 and 8) reviewed for activities did not have planned activities designed to meet their needs in accordance with the comprehensive assessments related to their interests and physical conditions. This was the case for one unidentified random resident as well. Findings include: 1. Resident #3 was admitted to the facility on 1/29/03 with diagnoses of profound impairment to both eyes (blind) and dementia with paranoid ideation. The resident's annual MDS, dated 3/7/06, documented her cognitive status as moderately	F 248	**F248 Activities** 1. Identified residents #2-#3-#5-#6-#8 will be re-interviewed by Activity Director for activity selection designed to meet their individual needs based on interests and physical condition, and care plan will be updated as appropriate. 2. In-service staff on needs for transportation to/from activities to improve participation in Activities. Revise Activity calendars to also include high function activities as well as increase choice of activities for cognitively impaired individuals. 3. Activity Director will complete activity assessment on residents at time of admission, quarterly, annually and if there is any change of condition to correctly identify activities to meet their needs in accordance with their interests and physical condition.	

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F 248	Continued From page 22 impaired with short term memory deficits. The same MDS indicated the resident's mental function varied throughout the day and that she participated in activities less than 1/3 of the time. The resident's "Initial Activity Assessment" dated 2/4/03 was not complete. The second page of the assessment had not been documented. The first page of the assessment checked twelve current interests for the resident. Interests included a hobby of collecting music and she liked the radio. However, there was no indication of what kind of music she enjoyed. The resident's condition had drastically changed since 5/21/06 when she was placed on comfort care and had become ill. (Please refer to F250 for details related to the resident's illness and plans for comfort care). The resident was not reassessed for her current needs. The resident's care plan, was dated 5/25/06 and included the following documentation: "Problem/Needs...[Resident #3] refuses group activities related to her blindness. Goals/Objectives...will attend one special event per month, listen to music from room twice per month for socialization R/T [related to] blindness. Approach...Invite and assist [resident #3] to and from special events, praise participation in events and activities. Likes music, will listen with a companion. Provide one on one in her room, ie: reading, socializing three times per week as tolerated. Assist as act[ivity] of int[erest] by describing what is occurring so that she can see it in her mind, (Paint a picture in her mind of fac[ility] happenings). Assure...that she is safe and that it is okay to participate in activities." The most current activities progress note, dated	F 248	4. Admin, D.O.N. or designee will observe activity participation and assure transportation needs are being met. Admin, D.O.N. or designee will review monthly activity calendar prior to posting for high-level activities as well as variety for cognitively impaired individuals Observation of activity participation will be reported at Continuous Quality Improvement meeting monthly, and will be followed until issue resolved. 5. Completion Date: 7/21/06	

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	135015	A. BUILDING _____ B. WING _____	06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNBRIDGE REHAB FOR PAYETTE	1019 3RD AVE S PAYETTE, ID 83661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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6/2/06, documented, "...Activity participation is none in a group setting. She refuses all gr. [group] act. [activities]. Act. Dept. [Department] does provide 1:1 3 x wk. [week] witch [sic] she states leave me alone all I want to do is sleep. She does not like the radio or TV turned on. She likes it quiet. Act. Dept. to cont[inue] to monitor for any further act. needs."

The resident was observed from 6/12/06 to 6/16/06 a total of fourteen times. She did not leave her bed and almost always had her eyes closed. She was usually not responsive. On 6/14/06 at 12:05 pm, the activity director came by the resident's room when the surveyor arrived to observe. The activity director asked the surveyor, "Is her radio still on?" The surveyor told the activity that no radio had been heard since observations had started on 6/12/06. The activity director stated, "Her roommate turns it off." A very faint sound of music could then be heard. The radio was not by the resident but across from the foot of her bed. The activity director was asked why it was not next to the resident. She stated there was no plug as they were being used for the mattress and oxygen. She then left the room and returned at 12:10 pm, with a surge protector so the radio could be plugged in next to the resident. The radio had Country/Western music playing.

Other activities of sensory stimulation, such as lotion massage or types of one to one activities that may be calming and appreciated by the resident were not observed. For instance, perhaps a family member could be called by name and a historical story could have been related to the resident. The type of music the resident preferred was not identified in the care

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F 248	Continued From page 24 plan. The resident was blind and may have appreciated some type of tactile stimulation to her hands or face. The facility did not explore ways to provide meaningful activities to resident #3 which met her changing physical and mental needs. 2. Resident #2 was admitted to the facility on 10-06-04 with diagnoses of pneumonia, congestive heart failure, atrial fibrillation and atherosclerosis. According to the quarterly MDS signed on 5/17/06, the resident's average time involved in activities was, "some-from 1/3 to 2/3 of time when awake". The care plan dated 5/26/06, does not reflect any problems related to activities. Review of the social history and assessment form summary, dated 4/26/06, stated, "...the resident does not leave his room most of the time. He lays in bed most of the day and watches TV..." A resident interview was conducted on 6/14/06 at approximately 7:35 am. The resident was asked by the surveyor about his activities. The resident stated that, "he mostly stayed in his room watching TV. Sometimes I play cards or read magazines." When the surveyor asked about activities outside his room, the resident stated, "I don't usually go out because they won't bring me back when I get extremely tired and start hurting. I generally like the activities they provide here, but it's just not worth it. I'm just too miserable waiting for them to bring me back to my room. Several times I had to wait as much as 30 - 45 minutes and that's just too long."	F 248		

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F 248	Continued From page 25 On 6/14/06 at 9:00 am an interview was conducted with the social services designee. It was stated that, "The staff offers the resident the chance to go to activities, but the resident almost always declines. Luckily, the resident's family, an ex-wife, comes in often to help with some of his needs and keeps him company. An interview with the activities director was conducted on 6/14/06 at 8:35 am. The director stated, "This resident does not like to leave his room, he just wants to stay there all of the time. I take the newspaper to him often. He also likes the old black and white movies on TV and sometimes plays cards. Most of the time he just lays there and watches TV. I also believe that he gets too tired when he goes to activities." The facility did not design an activity program based on his need to return to his room at the conclusion of the activity, in a timely manner to meet his physical needs. 3. Resident #5 was admitted to the facility on 11/09/05 with a diagnosis of quadriplegia. The MDS signed on 5/11/06 indicated that the resident's average time involved in activities, "is little less than 1/3 of the time awake." the MDS also indicated that the resident has a cognition level of "1". Review of the care plan, dated 5/26/06, revealed the following problems: - Problem 06, Alteration in mood: Hx (history) of depression; Approach 03, dated 11/09/05,	F 248		

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F 248	Continued From page 26 "Encourage increased socialization and participation in activities as a therapeutic use of distraction". - Problem 08, dated 1/18/06, Resident needs total assist from staff to partake in any type of physically demanding programs; Approach 02, dated 1/18/06, "Contact resident's mother for past interests (with resident's permission." Approach 03, dated 1/18/06, "Contact organizations w/ resources for Native Americans (with resident's permission). Approach 05, dated 1/18/06, "provide leisure education r/t (related to) assistive devices to aide in participation level." The activities progress notes from 11/08/05, 12/06/05, 3/04/06, and 5/08/06 noted that the resident liked to watch TV and listen to music. No further discussion of activities was mentioned. There was no mention of activities on the social progress notes dated 11/09/05, 11/17/05, 2/13/06, 2/25/06, 3/09/06 and 5/08/06. The Activity/Recreation Assessment form, dated, 11/17/05, noted that a past interest of the resident was reading. The resident's attitude was marked on the form as, "being cooperative and willing to try, and that his attitude in general, was interested." During a resident interview on 6/13/06 at 8:45 am, resident #5 discussed activities that he enjoyed. The resident stated, "I used to like reading books and magazines but it is very difficult as you know. I used to read about 6 years ago. I had a special reading table but it's been lost. That didn't happen here and I just never was asked so I didn't say	F 248		

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anything." When the surveyor asked the resident if he would like to try to read again, the resident said, "Sure."

On 6/14/06 at 8:10 am, a staff interview was conducted with the activities director. It was stated that, "The resident really likes the TV and videos. The library will only lend videos for 2 days, and this is not enough time for the resident. The staff at the facility decided to bring in videos to share with residents" The surveyor asked if there were other activities offered. The activities director stated, " I'm new in this job and am always looking for suggestions. I will be going to an in-service next month and hope to learn more about activities. So, I don't really have any other suggestions at this time."

There was no evidence that the facility followed up on the resident's interest in reading, contacted the resident's mother on past interests, contacted organizations with resources for Native Americans or provided assistive devices to aid in leisure education as outlined in the care plan.

4. Resident #6 was admitted to the facility on 9/25/03 with diagnoses of spinal stenosis, muscle weakness, lumbago, convulsions and depression.

The resident's record contained a physician progress note, dated 2/5/06, with the following documentation: "...She states that she is actually doing very well. Her only problem is boredom because they lost the activity director and not much is happening right now... When it was suggested that she be an activity organizer with some other friends, she did not think she could do that..."

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The resident's annual assessment, dated 5/31/06, documented the resident with modified independence for cognition and involved in activities some (1/3/to 2/3) of the time.

The resident's care plan, dated 6/13/06, did not identify a problem for activities. A problem for "Alteration in mood: depression." One of the approaches included, "Encourage socialization and participation in activities." No interests were documented to encourage the resident to participate. The resident did not have a plan to meet her individualized needs for activities.

The resident stated during interview on 6/15/06 at 9:00 am. She stated there was not a lot to do there. She liked what they do have but there is not enough to do. She said they had a new activity director and she sees to it that the bird feeder by the window in her room was filled with seeds. She indicated that she liked to read a little and usually just watched TV in her room until the meals were served. She said that she gets bored. The resident seemed to enjoy watching the birds but her bed was not next to the window so she would not always be able to see them.

During an interview with the activity director, on 6/15/06 at approximately 2:00 pm, she stated that she did not know she needed to have care planned activities for residents who were independent in doing there own activities.

5. On 6/12/06 at 3:10 pm, a surveyor was in the dining room at the end of the 300 hall. No one else was in the room and staff could not be observed in the hall. An unidentified resident

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could be heard in the adjacent small dining room calling for help repeatedly. The surveyor went into the dining room and a female resident was seated in a wheelchair and pushing herself back and forth by the organ. When the surveyor asked if she needed help she said, "Yes. Do you know how to do this? Am I supposed to add the numbers?" She was very confused and would again yell out help. The surveyor told the resident that assistance would be requested for her. The surveyor went up the 300 hall and found a nurse at the nurses' station who was passing medications. No one else was observed on the 300 hall. The nurse was told the female resident was calling for help and seemed anxious. The nurse replied, "Oh, she does that all the time. Wanders around in her wheelchair and calls out. I just gave her some pain medication so that will probably help her out." The surveyor asked if there was any type of activity the resident might find engaging. The nurse they had tries things like a busy box or mat and the resident won't engage in it. She stated the resident is just so confused there really isn't much to do for her. The resident was not being engaged in a meaningful activity to lower her anxious behavior symptoms.

6. Similar findings for lack of planned activities to meet the assessed needs were found for resident #8.

7. In addition, an activity was observed on 6/15/06 at 10:30 am. The activity was named "Book Worms" and was intended for residents who were cognitively able to listen to a story and understand. The volunteer reading the story to residents spoke so softly that residents who were hard of hearing would not be able to hear her. In

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addition, the activity director was present and after the activity began noticed the radio playing and walked over and turned it off. There were eight residents in the room for the activity. Within five minutes four of the residents were asleep. There was no interaction observed with the residents while the story was being told. Another activity named "Trivia" was scheduled for 12:15 pm. It was held when residents in the independent dining room at the end of the 300 hall were seated for lunch. The activity was over by 12:30 pm. The dining room receiving the activity was adjacent to a smaller dining room where all men sat to eat their meal. They were no involved in the activity as "Trivia" was only offered to the women who sat in the adjacent dining room. There was no activity or music played for the large dining room where the residents who needed assistance dined.

Later the same day, at approximately 2:00 pm, the activity director was interviewed. The DON was also present. The activity director was asked about how the facility ensures the day has ongoing meaningful activities for the residents. She stated that she does a sensory stimulation group daily for cognitively impaired residents every day. She indicated that exercise class is held daily and Trivia for residents who could participate more. She indicated that for evenings some times they have a movie. When asked about Bingo she stated they played the game three times a week.

The June 2006 activity calender was reviewed. On 6/15/06 (day of interview) the residents had Book Worms scheduled at 10:30 am, Sensory at 11:30 am, Word Trivia at 12:15 pm, Fiesta Cart at

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F 248	Continued From page 31 2:00 pm (this is a juice cart that gets pushed around the facility and stops at resident rooms to offer juice), Puzzle Mania at 3:00 pm and PM Cards at 7:00 pm. Residents who were cognitively impaired had possibly two things, Sensory and Fiesta Cart. Residents able to participate in Book Worms had an activity for approximately 1/2 hour and then nothing was scheduled until 12:15 pm when only select residents in the larger of the independent dining rooms were offered trivia for 15 minutes. The Fiesta Cart was then offered at 2:00 pm until 3:00 pm when they could participate in Puzzle Mania. Nothing else was offered the rest of the day until 7:00 pm when residents could play cards. This could be done any time of the day anyway for residents able to have a card game and did not require staff scheduling or assistance in all cases. If residents were up by 7:00 am and went to bed after 7:00 pm when the last activity was scheduled they received approximately 2-3 hours of scheduled activities in a 12 hour period. For the next day (6/16/06) only four activities were schedule. Sittercise at 10:30 am, Sensory at 11:30 am, Word Trivia at 12:15 pm and Bingo at 2:00 pm. Nothing was scheduled after the 2:00 pm Bingo game. This would be 5 hours until 7:00 pm with nothing for residents to do.	F 248		

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F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility did not ensure that medically-related social services were provided for 1 of 1 sample resident (#3) who was on comfort care. Findings include: Resident #3 was admitted to the facility on 1/29/03 with diagnoses of profound impairment to both eyes, rectal prolapse and dementia with paranoid ideation. The resident's annual MDS, dated 3/7/06, documented her cognitive status as moderately impaired with short term memory deficits. The same MDS indicated the resident's mental function varied throughout the day and that the resident had repetitive verbalizations, anger with self and others and anxious complaints at least five days a week. A physician progress note, dated 5/21/06, documented, "S[ubjective]: Her chief complaint is a change in level of consciousness noted just yesterday afternoon. The resident was noted to have some lt [left] sided weakness and unresponsiveness compared to the usual level yesterday...She noted that the lt side of her mouth seemed to be drooping and her tongue protruding slightly, leaning somewhat to the lt...It was noted that she was using both arms bilaterally but was	F 250	**F250 Social Services** 1. Identified resident #3 had very specific Advanced Directives in the medical record and was being followed as directed 2. Any resident on Comfort Care will be given health information, including risks involved regarding healthcare decisions 3. All orders for Comfort Care will be reviewed by IDT (interdisciplinary team) 4. End of Life committee will be formed and will meet with a care conference when comfort care is being considered, to assist in clarifying with resident, family, MD, and IDT (interdisciplinary team) in determining extent of "comfort care" as requested. Routine Care Conferences will be held as long as resident remains on comfort care to ensure that directives are being followed. 5. Completion Date: 7/21/06	

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not verbally responsive...O[bjective]: At the time of my visit she was sitting up to the dining room table and was using her lt hand to touch her face. She did not respond to my talking to her but was cooperative with the examination. It was noted that her hands were very cold...She was drooling somewhat which is not terribly unusual for her. Her rt [right] eye appeared to be a little bit soupy...Remarkable for very prominent, coarse rales and crackly sounds both on inspiration and expiration over the entire lt lung with the rt side being essentially clear...A[ssessment]: ...Suspect acute CVA with some lt sided facial weakness at least. Lt sided pneumonitis...dehydration...altered level of consciousness...chronic depression...moderate dementia...blindness...P[lan]: The nursing staff contacted her son yesterday after the acute change in her level of consciousness. The nurse has written that he requested comfort measures only...In light of her son's recommendation, we will encourage deep breathing and cough, try to position her on her rt side...hopefully promote clearing of the congestion of her lt lung. O2 will be offered to keep her SAT's [oxygen saturation levels] at 90% or above. She will be kept in her room in bed if necessary to avoid the hypotension that results from being upright and dehydrated, etc. She will have fluids encouraged and that apparently is primarily Ensure which is about the only thing they can get her to take. She will be given one dose of Zmax 2g [an antibiotic medication] suspension in her Ensure to see if we can clear some of her respiratory problems and otherwise continue comfort measures.

A nurse progress note contained the following documentation:

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F 250	Continued From page 34 A change of condition form, dated 5/20/06, documented, "Resident non-responsive...L [left] side of mouth drooping [with] tongue slightly protruding. Leaning to the L when up in w/c [wheelchair] to assisted D.R. [dining room]. Resident's son (P.O.A.) [Power of Attorney] notified- desires comfort measures only." 5/21/06 (6:15 pm)- "Dr....in this a.m. to see resident. Order for Z-max x 2 mg suspension received...Resident accepted and swallowed majority of 1 x dose...Resident coop[erative] [after] being informed of DX [diagnosis] of pneumonia. Minimal verbal response; minimal PO [by mouth] intake. O2 @ 3 L/Min via N/C [oxygen at 3 liters per minute via nasal cannula. Will cont[inue] to monitor." The resident was observed on 6/12/06 at 12:20 pm and 2:40 pm laying on her back in bed. She had a specialized air exchange mattress on her bed. Her eyes were closed and she had oxygen by nasal canula (nc) running at 2 liters per minute. The resident was observed on 6/13/06 at 6:50 am. She was in her bed, on her back with her eyes closed. Staff stated the resident had been ill with an upper respiratory infection. Seven additional observations (approximately hourly) were made that day. On only one occasion, at 11:55 am, she was observed to have her eyes open. She was asked by the surveyor how she was feeling. She replied, "Not so good." When asked if she was in pain she stated, "Let's just forget about it." She then did not respond when spoken to. The DON was interviewed on 6/15/06 at 2:30 pm. She was asked if the facility had attempted to	F 250		

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	135015	A. BUILDING _____ B. WING _____	06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNBRIDGE REHAB FOR PAYETTE	1019 3RD AVE S PAYETTE, ID 83661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 35 engage the resident in the decision not to treat her pneumonia. She said the comfort only care was decided when the resident was unresponsive and they spoke with her family member and personal representative. The DON was asked if there had been a window of opportunity for the resident to answer some questions regarding her preference to treat her pneumonia. She stated there had been. She agreed there was no documentation to indicate that the resident was asked or to what degree the family member had been educated about the choices regarding the resident's medical care. When asked if the facility had a policy for procedures of comfort care the DON said, "No, I was just working on that when survey started." When asked how the facility involved Social Services as part of a team to assist with these decisions, the DON said that Social Services was not involved. The guidelines for F250 indicate that medically-related social services include, "Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications." The facility did not provide resident #3 with medically-related services to make informed decisions regarding comfort care and decisions not to treat an illness.	F 250		

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F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and resident and family interview it was determined the facility did not receive necessary services to keep the interior free of pervasive odors on the 300 hall and to ensure that a light in the assisted dining room was clean and free of brown spots. This was the case for 4 of 9 (#6, 7, 8, & 9) sampled residents and for all residents who used these areas of the facility. Findings include: 1. During the initial tour of the facility, on 6/12/06 at 12:05 pm, the 300 hall had a strong smell of urine. The nurses' station was at the longest end of the hall and two dining rooms were at the other end. The dining room immediately adjacent to the hall was the larger of the two. It was the area for residents (all female) independent for dining, to have their meal. The smaller of the two dining rooms was entered from the larger dining room and was where other residents (all men) were seated to eat their meals. Before food was brought in to the dining rooms the smell of urine could be noted from the 300 hall. At 3:10 pm, the smell of urine was still pervasive in the 300 hall from the area of the nurses' station and into the dining room at the end of the hall. The dining rooms were also used for activities and for residents to use for their own personal use with families, visitor and each other. On 6/13/06 at 10:30 am, two surveyors met with	F 253	**F253 Housekeeping/Maintenance** 1. Identified room on 300 hall with pervasive urine odor, room was deep cleaned. Light coverings in West Dining Room were immediately removed and cleaned. 2. Daily deep cleaning of resident rooms that are incontinent of urine. Daily routine cleaning of common areas to include light fixtures as needed. 3. Housekeeping Supervisor will do housekeeping rounds to ensure facility is maintained in a sanitary, orderly, and comfortable manner. 4. Rounds of facility will be conducted by Administrator, D.O.N. or designee to include housekeeping and maintenance services are provided to maintain a sanitary, orderly comfortable environment. Results of rounds will be reported at monthly Continuous Quality Improvement committee and will be followed until resolved. 5. Date of Competition 7/21/06	

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F 253	Continued From page 37	F 253		

three residents who had rooms on the 300 hall and in one resident's room. They all indicated that odors had been a problem on the hall and in their rooms. (Please refer to F166 for more details regarding complaints about odors). After the meeting 11:55 am, the smell of urine was pervasive on the 300 hall. Residents were gathering to dine at the end of the hall. The odor remained throughout the rest of the survey observation days. (The last observation was made on 6/16/06 at approximately 1:45 pm). On 6/15/06 at 8:40 am, there was a strong urine odor in the hall. A visitor was in one of the rooms on the 300 hall. The surveyor asked the visitor if she could smell any odor. She said, "Yes. I often smell it when I come up the hall to visit my husband." She then started to look for the source of the odor in the room. She did find a brown stain on an incontinence pad and some yellow stains on some sheets in one of the beds. She left the room and was heard to tell a staff she needed to speak with her. Later at 10:25 am, the odor was overwhelming. It was a mixture of urine and feces odors.

2. On 6/14/06 at 10:25 am, a plastic overhead light cover in the assisted dining room was observed to have multiple yellow/brown colored spots. The light cover was located directly over a dining table. There were approximately 10-12 spots, measuring in size from 1/4 to 1/2 inch. There was also a yellow/brown colored area approximately 9 inches long by 1/2 inch wide on the end of the light cover.

An interview was conducted on 6/15/06 at approximately 2:10 pm with the maintenance man. The surveyor asked him to take a look at the light cover and to determine if the spots were

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F 253	Continued From page 38 on the inside or the outside. He stepped up on a chair and found the spots to be on the inside. He also stated that, "there had been a water leak problem above the light and these spots may have come from that, but, I will be sure to take care of this problem and clean up the spots."	F 253		

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: The facility did not ensure that an accurate and comprehensive assessment was completed for 1 of 7 sample residents (#8) who used a side rail. Findings include:	F 272	**F272 Comprehensive Assessment** 1. Identified resident #8 had side rails discontinued. P.T. to screen for use of trapeze bar. Resident #8 Care Plan will be adjusted as appropriate. 2. Any resident currently using side rails will have a comprehensive, accurate, standard reproducible assessment completed on functional capacity of side rail usage. 3. Residents will have comprehensive assessments completed, that will include functional capacity prior to implementation of side rails. 4. Audit of medical records for those individuals that use side rails will be completed quarterly, annually and if there is a change of condition. Medical record review for comprehensive, accurate assessment that includes functional capacity will be conducted by D.O.N. or designee on random residents that use side rails. Results of medical record reviews will be reported at monthly CQI committee until issue is resolved. 5. Completion Date: 7/21/06	

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F 272	Continued From page 40 Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA. His most recent quarterly MDS, dated 5/1/06, documented he used side rails for bed mobility and for restraints. (Refer to F278 for finding regarding MDS accuracy). In addition, the resident used one side rail for mobility according to a "Safety Device Evaluation" completed for side rail use on 6/1/06. Documentation indicated, "... 1/2 rails used for bed mobility...Device is an enabler? Yes. Bed mobility. Device is a restraint? No...Can the resident's extremities or head become wedged between the siderails and the mattress? No." The resident was observed on 6/15/06 at 10:25 am. He was in his room and lying on his bed. His bed was against the wall on his left side and he had a short side rail on his right side in the raised position. Later at 1:35 pm, the resident was observed for his ability to use the side rail for bed mobility. He did not, upon request by the CNA, demonstrate his ability to do this during this observation. It was noted at that time that the side rail was very loose and wobbled back and forth when grasped by the surveyor. It was also observed that there was a gap between the mattress and side rail of approximately 6-8 inches. This allowed room for the resident to entrap his limbs or body/head between the mattress and the side rail. The side rail was a hazard for the resident. This was not comprehensively assessed.	F 272		

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F 272	Continued From page 41 On 6/16/06 at 1:45 pm, resident #8 was again observed by the surveyor and a staff who also spoke the resident's first language (not English). The staff directed the resident to use the side rail to turn himself in the bed. The resident was able to reach over his body with his left arm and grab the side rail. He used it to roll himself to his right side. If the resident had to be cued to use the side rail for mobility, it should only have been up when he needed cares done. The assessment did not determine his need to have the side rail up all the time. Nor did it determine his safety while using it.	F 272		

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure the accuracy of MDS assessments. This affected 3 of 11 (#2, 7 & 8) sampled residents whose assessments were reviewed. The findings include:	F 278	**F278 Resident Assessment** 1. Identified residents #2-#7-#8 will have MDS corrections completed 2. Accurate MDS assessments will be completed on each resident upon admission, quarterly, annually, and if there is a change of condition. 3. In-service IDT (Interdisciplinary team) on accuracy of coding of MDS Audits will be performed on accuracy of MDS coding by D.O.N. and Regional Consultant as scheduled 4. Results of audits will be reported to CQI committee and followed until issue resolved 5. Completion Date: 7/21/06	

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F 278	Continued From page 43 1. Resident #7 was originally admitted to the facility on 9/10/05 and re-admitted 1/07/06 and again on 5/01/06. The resident's diagnoses included status post cerebral vascular accident and gastro-intestinal bleeding. The MDS with the assessment date of 5/14/06, indicated the resident's influenza vaccine and pneumococcal vaccine were up to date. The documentation of the pneumococcal vaccine could not be found in the record. The DON was asked to locate the documentation on 6/13/06 at approximately 1:30 pm. On 6/14/06 at 9:35 am, the DON handed a surveyor a copy of a medication record with the pneumococcal vaccine signed off as being administered on 6/13/06. The DON stated, "It was done yesterday." The DON explained that the facility had checked all records and could not confirm that the vaccine had been administered or that the resident had received the vaccine at the doctor's office. Accurate MDS coding of the vaccines would be an opportunity to ensure that a resident was up to date with the flu and pneumococcal vaccines. 2. Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA. His admission MDS, dated 11/17/05, documented he was usually continent of bowel. His most recent quarterly MDS, dated 5/1/06, documented he was continent of bowel. However, the bowel	F 278		

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records for April 2006, documented he was incontinent of bowel for 12 days of 30 days in April. This was usually documented for night shift but the resident was occasionally incontinent of bowel on day shift and evening shift as well. For the month of May the bowel records documented incontinence of bowel for 18 of 31 days in the month. The current MDS did not reflect an accurate assessment for bowel continence of this resident.

In addition, the resident used one side rail for mobility according to a "Safety Device Evaluation" completed for side rail use on 6/1/06. Documentation indicated, "... 1/2 rails used for bed mobility...Device is an enabler? Yes. Bed mobility. Device is a restraint? No..."

However, the MDS completed on 5/1/04 documented that side rails were used for bed mobility and were also for a restraint. This was not an accurate assessment since the facility determined the side rail was not a restraint.

3. Resident #2 was originally admitted to the facility on 10/06/04, and was readmitted the last time on 4/24/06. The resident's diagnoses include congestive heart failure, atrial fibrillation and atherosclerosis.

The MDS, dated 5/17/06, indicated that resident #2's pneumococcal vaccine was offered but declined.

The declination documentation could not be found in the resident's chart. The DON was asked to locate the documentation on 6/13/06 at approximately 1:30 pm.

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F 278	Continued From page 45 On 6/14/06 at approximately 9:30 am, the DON stated,"The vaccine had been given yesterday (6/13/06)." The DON explained that the facility had not been able to find the records or a confirmation date. Accurate coding on the MDS would be an opportunity to ensure that the pneumococcal vaccines were up to date. During the Exit Interview on 6/16/06 at 2:00 pm, a surveyor asked the staff to send a copy of the declination of the pneumococcal vaccine, if found, to our facility by the close of business on Monday, 6/19/06. The information has not been sent.	F 278		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interview it was determined the facility did not review and revise care plans for 4 of 11 residents (#3, 6, 7, and 10) whose care plans were reviewed. The findings include: 1. Resident #7 was initially admitted to the facility on 9/10/05 and readmitted on 1/17/06 and again on 5/01/06, with diagnoses of status post cerebral vascular accident and gastro-intestinal bleeding. The "Fall Risk Assessment," indicated the resident had been evaluated and found to be at a high risk for falls on 9/10/05 (score of 12), 10/16/05 (score of 14), 11/10/05 (score of 14),	F 280	**F280 Comprehensive Care Plans** 1. Identified residents #3-#6-#7-#10 Care Plans were updated as necessary 2. All other residents will have Care Plans reviewed and updated per Care Plan schedule 3. In-service LN and IDT (Interdisciplinary team) on 3-part forms as process in Care Plan updates. In-service IDT on Care Plan updates as part of annual, quarterly reviews and if there is a change of conditions 4. Care Plans will be monitored on an ongoing basis through focused committees Results of audits will be reported to CQI committee and followed until issue resolved 5. Date Completed: 7/21/06	

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F 280	Continued From page 47 and 5/02/06 (score of 20). A score of 10 or higher indicated a high risk for falls. The care plan dated 3/29/06, indicated the resident had been identified as being at risk for falls because of decreased safety awareness and lower extremity weakness. The care plan indicated the problem had been identified on 1/17/06. An approach to the problem, dated 1/17/06, stated, "Pressure alarm to chair to alert staff of attempts at unassisted activity." The "Care Plan Problem List," dated 3/29/06, had a hand written note dated 6/05/05. The hand written note stated, "Res [resident] using a tilted w/c [wheelchair] to enable him to be [up] out of bed. Dc'd [discontinue] self-releasing seat-belt. No longer needed. Res. uses 1-1/2 rail for mobility while in bed." On 6/13/06, the resident was observed at the following times to be up in the tilted w/c with no pressure alarm in place: a. 11:50 am - Transferred from bed to w/c via a mechanical lift by 2 CNAs. No pressure alarm observed in the w/c. After transfer, one of the CNA's pushed the w/c out of the room. The CNA stated, "[resident] will go to the dining room in awhile." b. 12:20 pm - In the hallway. Resident sitting in the tilted w/c. No pressure alarm in place. c. 12:30 pm - In the dining room, sitting in the tilted w/c. No pressure alarm in place. d. 1:30 pm - Resident sitting in the tilted w/c, in the hallway, near his room. No pressure alarm in place.	F 280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNBRIDGE REHAB FOR PAYETTE	1019 3RD AVE S PAYETTE, ID 83661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 48 On 6/15/06 from 2:50 pm to 3:20 pm, the DON and the administrator were interviewed concerning falls and interventions. The DON stated the resident should be re-evaluated to determine if the pressure alarm was still needed. 2. Resident #10 was admitted to the facility on 1/22/06 and re-admitted on 2/16/06, with diagnoses of Alzheimer's dementia, anxiety disorder, and chronic obstructive pulmonary disease. The "Fall Risk Assessment," indicated the resident was at high risk for falls on 1/22/06 (score 16), 2/16/06 (score 14), 5/15/06 (score 14), and 5/30/06 (score 16). The quarterly MDS for the reference date of 5/13/06, indicated the resident had fallen within the past 31 to 180 days. The "Event Management System," dated 5/04/06 at 7:30 pm, indicated the resident had been found sitting on the floor, next to the wheelchair. The intervention implemented after the investigation was to place the resident on a 2 hour toileting program. The care plan dated 6/05/06, indicated the resident had been identified as being at risk for falls related to confusion, combativeness, delusions and agitation. An approach to the problem indicated the resident would be evaluated for a toileting program. That approach was dated 5/15/06. Another approach, dated 5/15/06 stated, "Identify factors that increase resident's potential for falls/injury (i.e. obstacles, unmet needs, confusion, agitation)." The care	F 280		

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plan did not indicate the resident was to be toileted every 2 hours.

On 6/15/06 from 2:50 pm to 3:20 pm, the administrator and DON were interviewed concerning falls and interventions. The DON stated the resident had told the staff she had fallen because she needed to go to the bathroom and the intervention was to toilet the resident every 2 hours.

The care plan was the road map used by all healthcare personnel to follow appropriate intervention and approaches to prevent falls. The care plan had not been reviewed and updated as needed to ensure appropriate care was provided.

3. Resident #3 was admitted to the facility on 1/29/03 with diagnoses of profound impairment to both eyes, rectal prolapse and dementia with paranoid ideation.

The resident's annual MDS, dated 3/7/06, documented her cognitive status as moderately impaired with short term memory deficits. The same MDS indicated the resident's mental function varied throughout the day and that she participated in activities less than 1/3 of the time. The resident's "Initial Activity Assessment" dated 2/4/03 was not complete. The second page of the assessment had not been documented. The assessment checked twelve current interests for the resident when the first page of the form was completed on 2/4. At that time of the resident had a hobby of collecting music and liked the radio. However, there was no indication of what kind of music she enjoyed. The resident's condition had drastically changed since 5/21/06 when she was

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placed on comfort care and had become ill. (Please refer to F250 for details related to the resident's illness and plans for comfort care).

4. Similar findings included resident #6 who had no care plan for activities to meet her current interests.

The resident's care plan, was dated 5/25/06 and included the following documentation: "Problem/Needs...[Resident #3] refuses group activities related to her blindness. Goals/Objectives...will attend one special event per month, listen to music from room twice per month for socialization R/T [related to] blindness. Approach...Invite and assist [resident #3] to and from special events, praise participation in events and activities. Likes music, will listen with a companion. Provide one on one in her room, ie: reading, socializing three times per week as tolerated. Assist as act[ivity] of int[erest] by describing what is occurring so that she can see it in her mind, (Paint a picture in her mind of fac[ility] happenings). Assure...that she is safe and that it is okay to participate in activities."

The most current activities progress note, dated 6/2/06, documented, "...Activity participation is none in a group setting. She refuses all gr. [group] act. [activities]. Act. Dept. [Department] does provide 1:1 3 x wk. [week] witch [sic] she states leave me alone all I want to do is sleep. She does not like the radio or TV turned on. She likes it quiet. Act. Dept. to cont[inue] to monitor for any further act. needs."

The resident was observed from 6/12/06 to 6/16/06 a total of fourteen times. She did not

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leave her bed and almost always had her eyes closed. She was usually not responsive. On 6/14/06 at 12:05 pm, the activity director came by the resident's room when the surveyor arrived to observe. The activity director asked the surveyor, "Is her radio still on?" The surveyor told the activity that no radio had been heard since observations had started on 6/12/06. The activity director stated, "Her roommate turns it off." A very faint sound of music could then be heard. The radio was not by the resident but across from the foot of her bed. The activity director was asked why it was not next to the resident. She stated there was no plug as they were being used for the mattress and oxygen. She then left the room and returned at 12:10 pm, with a surge protector so the radio could be plugged in next to the resident. The radio had Country/Western music playing.

The type of music the resident preferred was not identified in the care plan. The resident did not have a care plan to reflect changes in her activity needs related to the decline in her condition.

Another problem identified for alteration in nutrition contained approaches including, "Encourage [resident #3] to eat 75% of her meal. Offer her a replacement if she consumes less than 50%. Tell [resident #3] where her food is by using the clock method. Remove entree/veg [vegetable] from resident's tray per her request...Encourage to remain upright for at least 30 minutes following meals, refuses to do so, wants to go to her room immediately after meals.

The resident was placed on Comfort Care as of 5/21/06. She no longer went to the dining room for meals, no longer left her bed and was not

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F 280	Continued From page 52 consuming anything but Ensure supplement. The nutrition approaches were not current to the resident's condition. The care plan was not revised. 4. Similar findings for resident #6.	F 280		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review it was determined that services to keep fingernails trimmed and cleaned were not provided for 1 of 10 sample residents (#8) who needed assistance from staff to maintain good grooming and hygiene. Findings include: Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA. His admission MDS, dated 11/17/05 and his most recent quarterly MDS, dated 5/1/06, documented he required extensive assistance for hygiene. The resident's care plan, dated 6/13/06, documented an identified problem for, "ADL self care deficit related to CVA with (R) sided	F 312	**F312 Activities of Daily Living** 1. Identified resident #8 had nail care performed. 2. All current residents will be checked for adequate nail care. 3. L.N. and C.N.A. in-service on routine nail care. 4. Treatment book audit monthly to assure nail care is completed as scheduled Random checks on nail care will be done weekly by Admin. /D.O.N. or designee Results of audits and monitoring information will be reported at CQI committee meeting monthly, and will be followed until resolved. 5. Completion Date: 7/21/06	

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F 312	Continued From page 53 weakness." Approaches included, "Requires extensive assist of one for transfers, dressing, grooming and oral care." The resident was observed with a CNA on 6/15/06 for positioning and side rail use. He was noted to have finger nails that were approximately 3/8 of an inch long with built up dark matter under the finger nails. The resident was not receiving services to keep his finger nails trimmed and cleaned and was unable to do this for himself.	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and review of facility event reports it was determined the facility did not ensure that 1 of 4 sample residents (#8) with identified incontinence received services to restore as much bladder function as possible. Findings include:	F 315		

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F 315	Continued From page 54 Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA. His admission MDS, dated 11/17/05, documented the resident as frequently incontinent of urine. His most recent quarterly MDS, dated 5/1/06, documented that he was incontinent of urine. A "Bladder Retraining Assessment" form was in the resident's record. The form was not completed. The only information at the bottom of the form was the resident's name, physician's name and record and room numbers. There was no documentation in the record of an established voiding pattern. The resident's care plan, dated 6/13/06, documented an identified problem for, "ADL self care deficit related to CVA with (R) [right] sided weakness." Approaches included, "Requires extensive assist of two for toileting. Toilet Q [every] 2 hrs [hours] to help establish/regulate bladder post CVA." Another problem identified, "Alt. [Alteration] in urinary Elim[ination] pattern, frequently incontinent related to: CVA...Approach...Encourage resident to request toileting. Provide immediate perineal care following incontinent episodes. Uses pads for incont[inent] mgmt. [management] check Q 2 hrs and change prn [as needed]." The DON was interviewed on 6/15/06 at 2:30 pm. She was asked what the facility had done to assess the resident's incontinence for development of a toilet schedule. She agreed the bladder assessment was not done. She did provide two forms that had not been in the record.	F 315		

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F 315	Continued From page 55 One form was a "Scheduled/Prompted Toileting Program Record." The date started was 2/7/06 and the last date was 2/13/06 (seven days). At the top of the form hand written instructions documented, "Toilet before and after meals." Under each date there were two columns for staff to indicate if the resident was incontinent or voided. Spaces were provided for hourly documentation. For the seven days only day 2/8 had documentation that the resident was incontinent and had voided at 1:00 pm. None of the other days from the hours of 7:00 am to 6:00 pm had any documentation. There was documentation for 5:00 am on 2/7, 2/8, 2/10, 2/11 and 2/12 for incontinence. For 2/9 and 2/13 at 6:00 am he was incontinent. The back of the form required the same information for dates 2/14 to 2/20 (7 days) and had similar documentation as the prior days. There was no indication the resident was toileted before or after lunch or dinner ever. There was no way to establish if he was ever actually offered toileting or just changed when incontinent. The form did not document he was being toileted before and after meals and did not provide any meaningful information to assess the resident for an individualized toileting plan. The second form was a "Voiding Pattern Assessment Tool." This form was incomplete and had not been initiated until 6/10/06 and ended on 6/11/06. The resident had already been in the facility for seven months. The DON stated that they were starting over as the assessment had not been completed. The form required documentation to indicate if the resident was a little wet, very wet, dry, toileted (cc amount) and if he took a drink (include cc amount) at that time. There were hourly times to document these areas	F 315		

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F 315	Continued From page 56 on each day. The DON said, "We aren't doing it hourly." On 6/10 the resident was found to be very wet at 7:00 am, but the next documentation, was not for four hours at 11:00 am, when he was again very wet. It could not be determined if he was offered toileting. There was no documentation for either day at any time that the resident was toileted except for 6/11 at 7:00 pm, when he was checked as toileted and dry. (No cc's documented). It was not possible for the facility to establish a pattern with this limited information. The facility had not provided bladder training for the resident to help establish an individualized toileting program and either promote improvement in his bladder control or prevent further decline. Please also refer to F324 for additional findings regarding falls that were related to toileting issues for this resident.	F 315	**F315 Urinary Incontinence** 1. Identified resident #8 will have bladder assessment completed. 2. Any resident incontinent of urine will have bladder function assessment completed at admission, quarterly and if there is a change of condition. 3. S.D.C. will review any resident identified with incontinence of urine to assure they receive appropriate treatment and services to prevent a UTI, and to restore as much normal bladder function as possible. 4. Audit of incontinent residents will be completed by D.O.N. or designee during routine bowel/bladder committee	
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: 2. Resident #8 was admitted to the facility on 11/11/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA.	F 319	Results of audit will be reported to monthly CQI committee, and will be followed until issue resolved 5. Completion Date: 7/21/06 **F319 Mental and Psychosocial Functioning** 1. Residents identified #8 and #5 will have access to counseling to meet needs if desired	

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F 319	Continued From page 57 The history and physical, dated 11/1/05, contained the following documentation: "...patient is completely dependent...Patient has increasing anger and family is wondering whether or not he is having suicidal thoughts as well...Patient is completely wheelchair dependent and does not get around with anything else. He mainly spends the day sitting in the wheelchair..." A nurse progress note, dated 11/21/05, documented, "...He has a hx [history] of depression and is taking antidepressant to help with this. His facial expression is very complacent. Does not appear happy. Will answer when told to however in 1 word or gesture..." On 2/24/06 a nurse note documented, "...He does not interact [with] staff unless you talk to him 1st. He will make eye contact but flat affect..." His most recent quarterly MDS, dated 5/1/06, documented that he had mood and behavior patterns of sad, pained, worried facial expressions and reduced social interactions. He had behavioral symptoms of resisting care. These concerns had not been documented on prior MDS assessments completed for admission on 11/17/05 or a quarterly completed on 2/11/06. However, the resident's recapitulation (RECAP) of physicians orders for June 2006 documented he had been receiving "Effexor XR 150 mg PO [by mouth] QD [every day]" for a diagnosis of depression. A nurse progress note, dated 5/4/06, documented, "...Very quiet isolated man who stays to himself watch [ethnic name] TV in room..."	F 319	2. All residents will be assessed for counseling needs at admission, quarterly, annually, if they have a change of condition, and for any special circumstantial need. 3. Social Service Consultant will review progress note documentation to assure that mental or psychosocial adjustments needs are being met for residents Consultant report will be given to Administrator 4. Admin., D.O.N. or designee will interview residents to assure counseling needs are being met. Results of interviews will be reported at CQI monthly and will be followed until resolved. 5. Date Completed: 7/21/06	

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F 319	Continued From page 58 The resident's care plan, dated 6/13/06, documented an identified problem dated 11/14/05, "Alteration in mood: depression." Approaches included, "Identify expressions of depressed/negative behavior (ie; nothing matters, would rather die, etc.) Allow res[ident] to retain as much control as possible without a threat to self or others. Encourage increased socialization and participation in activities as a therapeutic use of distraction. Evaluate effectiveness of antidepressant medication report problems to physician." The care plan did not contain an activity plan. The resident had not been seen by a counselor or psychiatric doctor per the DON when interviewed on 6/15/03 at approximately 2:30 pm. There were no social service notes regarding attempts to assist the resident in receiving some treatment for his depression. The resident isolated himself and did not talk to anyone unless he gave one word answers or gestures. He did not participate in activities. The resident was in need of counseling to assist him in coping with a debilitating stroke and life in a nursing home. Based on observations, resident and staff interviews, and records, it was determined the facility did not meet the residents's needs for professional counseling. This resulted in 2 of 9 sampled residents (#5) and (#8) having problems with isolation and depression. Both residents needed assistance in making adjustments to loss and the need for nursing home care. The findings include:	F 319		

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F 319	Continued From page 59 1. On 11/09/05 resident #5 was admitted to the facility with a diagnosis of quadriplegia. The quarterly MDS signed on 5/11/06 indicated that the resident's indicator's of depression, anxiety, sad mood are, "I. Sad, pained, worried facial expressions-e.g., furrowed brows," and an indicator of "2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)". The mood persistence indicator was a "1" which indicated that "depression, sad or anxious mood were not easily altered by attempts to 'cheer up', console or reassure the resident over the last 7 days. Review of the social progress notes, dated 2/25/06, revealed that the social services designee spoke with the resident concerning the death of his brother. It had happened approximately two weeks earlier and his family had not notified him. The resident had stated that "a couple of months earlier his uncle had died and his family had not told him about this either. He had kept his hurt in and had not told anyone and that he had taken his pain out on the staff. Later he apologized to the staff." The social services designee indicated in his notes that he would ask the senior counselor to talk with the resident. Review of a depression scale form, dated 1/17/06, indicated that the resident had very few interests, that his life was empty, that he was in poor spirits most of the time, that he was unhappy most of the time, that it was not wonderful to be alive and that his situation was hopeless. Review of the recreation initial assessment - social domain form, no date indicated, revealed	F 319		

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that section C was given a negative score of "3" for social isolation. The indicators are as follows: 1) Refuses to attend all or most recreation activities, 2) Receives less than two social visits per week, and 3) Initiates and maintains social conversations with residents or staff less than once per day.

An interview was conducted on 6/14/06 at 8:45 am, with the social services designee. The surveyor asked if a counselor was seeing the resident. The social services designee said, "no." When asked why not, it was revealed that the counselor had said the resident was not old enough for his services (he counseled only the elderly). The social services designee had checked around the area with other similar facilities to find out if they had a counselor available and was told that they did not have one. He stated that "he is still checking this out." He also indicated that the facility had gotten the resident a calling card and a hands-free phone so that he could talk to his family more often. However, it was still very difficult to get these calls coordinated. When asked about the resident's door being closed most of the day and night, it was stated that "he likes it this way."

A resident interview was conducted on 6/13/06 at 8:45 am. When asked if the staff treated the resident with respect and if they knew something about him as a person, the resident's reply was, "I like most everybody here and they do treat me with respect, but they're too busy to spend any time with me and get to know me. The nurses yell at the aides a lot, and then they come in and stare at them so that they'll hurry up with whatever they're doing. The staff mostly yells at

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each other. Basically, I just pretty much go along with things around here." When asked if he shared personal thoughts with anyone the resident said, "no."

2. Resident #8 was admitted to the facility on 11/11/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA.

The history and physical, dated 11/1/05, contained the following documentation: "...patient is completely dependent...Patient has increasing anger and family is wondering whether or not he is having suicidal thoughts as well...Patient is completely wheelchair dependent and does not get around with anything else. He mainly spends the day sitting in the wheelchair..."

A nurse progress note, dated 11/21/05, documented, "...He has a hx [history] of depression and is taking antidepressant to help with this. His facial expression is very complacent. Does not appear happy. Will answer when told to however in 1 word or gesture..." On 2/24/06 a nurse note documented, "...He does not interact [with] staff unless you talk to him 1st. He will make eye contact but flat affect..."

His most recent quarterly MDS, dated 5/1/06, documented that he had mood and behavior patterns of sad, pained, worried facial expressions and reduced social interactions. He had behavioral symptoms of resisting care. These concerns had not been documented on prior MDS assessments completed for admission on 11/17/05 or a quarterly completed on 2/11/06. However, the resident's recapitulation (RECAP) of

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physicians orders for June 2006 documented he had been receiving "Effexor XR 150 mg PO [by mouth] QD [every day]" for a diagnosis of depression.

A nurse progress note, dated 5/4/06, documented, "...Very quiet isolated man who stays to himself watch [ethnic name] TV in room..."

The resident's care plan, dated 6/13/06, documented an identified problem dated 11/14/05, "Alteration in mood: depression." Approaches included, "Identify expressions of depressed/negative behavior (ie; nothing matters, would rather die, etc.) Allow res[ident] to retain as much control as possible without a threat to self or others. Encourage increased socialization and participation in activities as a therapeutic use of distraction. Evaluate effectiveness of antidepressant medication report problems to physician." The care plan did not contain an activity plan.

The resident had not been seen by a counselor or psychiatric doctor per the DON when interviewed on 6/15/03 at approximately 2:30 pm. There were no social service notes regarding attempts to assist the resident in receiving some treatment for his depression. The resident isolated himself and did not talk to anyone unless he gave one word answers or gestures. He did not participate in activities. The resident was in need of counseling to assist him in coping with a debilitating stroke and life in a nursing home.

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F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations, review of material safety data sheets (MSDS) and staff interviews, it was determined that the facility did not ensure that residents were not exposed to chemical, electrical, mechanical, slip/trip/fall and pinch point/entrapment. This resulted in the following environmental hazards: 1. Electrical hazards and slip/trip/fall hazards, on the floor and at various heights, were found in 1 of 1 unlocked Fire Riser room. This had the potential to affect all ambulatory, wheelchair, and cognitively impaired residents who resided in the facility. 2. Chemicals in 1 of 3 utility rooms were found in an unlocked room. This had the potential to affect all ambulatory, wheelchair, and cognitively impaired residents who resided in the facility. 3. Chemicals and personal items in 1 of 2 shower rooms, were found in an unlocked room. This had the potential to affect all ambulatory, wheelchair, and cognitively impaired residents who resided in the facility. 4. Splintered hand rails were found in the 100 hall and by the facility entrance area. This had the potential to affect anyone in this hallway of the facility. 5. Loose side rails that could cause pinch point/entrapment, were found on the beds of 2 of 10 sampled residents (#4 and #8), evaluated for restraints.	F 323	**F323 Accidents** 1. Loose side rails on identified resident #4 were replaced by Maintenance Director. Loose side rails on identified resident #8 were removed. 2. The facility will ensure that resident environment remains as free as hazards as possible. Rooms that contain electrical hazards, slip/trip/fall hazards or potential access to chemicals will have self locking doors in place with access to key beyond resident reach. Splintered, gouged and/or splintered handrails were immediately sanded, and then later stained. 3. In-service Staff on maintaining an environment free of potential accident hazards and notification of maintenance of such potential hazards. 4. Admin., D.O.N. or designee will make rounds to ensure that the facility does not expose residents to chemical, electrical, mechanical, slip/trip/fall and pinch/point/entrapment environmental hazards. Results of rounds will be reported to CQI committee monthly and will be followed until issue resolved. 5. Date of Completion: 7/21/06	

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F 323	Continued From page 64 The findings include: 1. On 6/12/06 at 2:30 pm, the door to 1 of 1 Fire Riser rooms, located in the 200 hall was found to be unlocked. The following issues were discovered: a) Electrical hazards - There were exposed electrical conduit and an electrical box found in the Fire Riser room that was approximately 4 feet from the floor. b) Slip/trip/fall hazards - Several valves and large diameter pipes for fire suppression were approximately 2 feet to 5 feet from the floor. On the floor was an empty mop bucket and a vacuum cleaner. On 6/12/06 at approximately 2:35 pm, the maintenance man explained that, "I keep it (door) locked at all times because of the fire suppression system. The housekeepers must have opened it to get the vacuum out and forgot to lock it." 2. On 6/12/06 at approximately 2:45 pm, chemicals were found in 1 of 3 utility rooms. This utility room was located near the tub room on the 200 hall and were found to be unlocked. Inside the utility room chemicals were found on the floors, and on attached wooden shelves. The chemicals include: *"Crew Toilet Bowl Cleaner" a 64 ounce spray bottle, label read "Danger ammonium chloride," was found on the floor. Review of section 3, the hazards identification section of the MSDS stated, "corrosive to eyes and may cause blindness;	F 323		

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F 323	Continued From page 65 corrosive to skin, may cause permanent damage; if inhaled may cause irritation and corrosive effects to nose, throat and respiratory tract; if ingested may cause burns to mouth, throat and stomach." *"Virex II 256 disinfectant" 64 ounce bottle, label reads "Danger - ammonium chloride," was found on the floor. Review of section 3, the hazards identification section of the MSDS stated, "eye contact, corrosive, may cause permanent damage including blindness; skin contact, corrosive, may cause permanent damage; if inhaled may cause irritation and corrosive effects to nose, throat and respiratory tract; if ingested may cause burns to mouth, throat and stomach. *"Neutral Cleaner" 64 ounce bottle found on the floor. Review of section 3, the health hazards identification section of the MSDS stated, "eyes - severe irritation; skin - severe irritation; inhalation may cause irritation to nose, throat and respiratory tract; ingestion may cause irritation to mouth, throat and stomach; medical conditions - persons with pre-existing skin disorders may be more susceptible to irritating effects. *"Glance glass and multi-purpose cleaner" 64 ounce bottle found on the floor, label reads "Danger - Corrosive." Review of section V, Health hazard data section of the MSDS stated, "prolonged or repeated contact of product with skin may cause minor irritation; flush eyes with water for 15 minutes, if irritation persists seek medical aid, if product gets on skin, remove with soap and water; persons with pre-existing skin disorders may be more susceptible to irritating effects." *On the floor by the utility sink in a box were 2 plastic containers of Crew toilet bowl cleaner, 64 ounces each, with ammonium chloride.	F 323		

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F 323	Continued From page 66 *A 32 ounce plastic container of Crew toilet bowl cleaner was found on an attached wooden shelf approximately 5 feet from the floor. Label stated "Danger - Poison." *Chlorine bleach powder, a 1 pound 5 ounce box, was found on a second attached wood shelf, approximately 4 feet from the floor. The label read, "Warning - causes severe eye irritation, avoid contact with eyes. Harmful if swallowed. Keep out of reach of children." 3. On 6/12/06, at 2:55 pm, the door to 1 of 2 shower rooms, on the 200 hall, was found open with the key in the lock. The door could be opened without turning the key. The following items were found in an unlocked wooden wall cabinet, approximately 5 feet from the floor, with the key hanging inside the cabinet: TLC Anti-dandruff shampoo, a 14.5 ounce plastic bottle; a bottle of roll-on deodorant (label not readable). The following item was found hanging on a hand rail in the same shower room: A spray bottle of Virex II 256 Disinfectant - 200 cc's (cubic centimeters), label reads "Danger - ammonium chloride." On 6/12/06 at 3:08 pm, the surveyor discussed the unlocked chemicals with the maintenance man. The maintenance man stated, "They need to be locked up, they (meaning the housekeepers) know that." 4. On 6/14/06 at 11:10 am a wooden hand rail across from the kitchen," was found to have a	F 323		

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F 323	Continued From page 67 gouged and rough edge about the size of a quarter on the corner of the hand rail. A length of rail approximately 10 feet long had a straight line where wood was scratched, and there was a 3 inch splinter on the end of the rail. Another hand rail near the entrance area in the 100 hall, that was approximately 10 feet long, had very rough and gouged areas along the rail. On 6/14/06 at 2:10 the surveyor showed the maintenance man the rails. He agreed that the splinter and gouged areas on the rails needed to be sanded. On 6/15/06 at approximately 3:00 pm, the maintenance man showed the surveyor that he had taken care of the problems on the hand rails and was getting ready to have them stained. 5. Resident #4 was admitted to the facility on 1/30/06 with diagnoses of cerebral vascular accident (CVA) with resolving hemiplegia, hypertension, hypothyroidism, kyphoscoliosis, osteoarthritis and depression. The resident was observed on 6/12/06 at 2:40 pm. She was in bed and an aide was in the room helping her get up. It was noted that her bed was against the wall on her left and she had a short side rail to her right which was in the raised position. She was asked by the surveyor if she ever used the side rail for transferring out of bed. She said she did sometimes. The aide assisted the resident out of bed but the resident did not use the side rail to get up from the bed. On 6/14/06 at 1:50 pm, the resident was observed	F 323		

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sitting in her wheelchair and facing the side of her bed. She had her right hand on the siderail and was using it in an attempt to stand up and get into her bed. It was noted that the side rail wobbled back and forth as she pulled and pushed against it. The surveyor helped her put her call light on and waited with her until staff came to her room. It was noted at this time that there was a gap between the mattress and the side rail of approximately 6-8 inches. This was ample room for the resident to wedge a body part between the mattress and the side rail. The side rail was hazardous for the resident who was unsteady and had fallen transferring herself to or from bed on several occasions. Please refer to F324 for findings related to falls not prevented for resident #8.

6. Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA.

The resident was observed on 6/15/06 at 10:25 am. He was in his room and lying on his bed. His bed was against the wall on his left side and he had a short side rail on his right side in the raised position. Later at 1:35 pm, the resident was observed for his ability to use the side rail for bed mobility. He did not upon request demonstrate his ability to do this during this observation. It was noted at that time that the side rail was very loose and wobbled back and forth when grasped by the surveyor. It was also observed that there was a gap between the mattress and side rail of approximately 6-8 inches. This allowed room for the resident to entrap his limbs or body between the mattress and the side rail. The side rail was a

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F 323	Continued From page 69 hazard for the resident. Upon meeting with the Administrator and DON later at 3:40 pm they were advised that the side rails were unsafe. They indicated the maintenance supervisor would work on them. On 6/16/06 at 1:45 pm, resident #8 was again observed by the surveyor and a staff who also spoke the resident's first language (not English). The staff directed the resident to use the side rail to turn himself in the bed. The resident was able to reach over his body with his left arm and grab the side rail. He used it to roll himself to his right side. It was observed that the side rail still wobbled as he used it and the gap between the rail and the mattress was to large (6-8 inches). Later at 2:00 pm, the maintenance supervisor stated he had tried to fix the side rails but they could not be made any tighter than they already were. The Administrator and DON were present and indicated they would take care of the problem by getting new side rails if needed.	F 323		
F 324 SS=E	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, it was determined the facility did not ensure appropriate supervision in order to prevent falls. This affected 4 of 11 (#1, 4, 8, & 10)	F 324	**F324 Accidents** 1. Identified residents #1-#4-#8-#10 was reviewed for assistive devices needed to prevent falls. Care plans were updated as appropriate on identified residents.	

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F 324	Continued From page 70 sampled residents whose accident reports were reviewed. The findings include: 1. Resident #4 was admitted to the facility on 1/30/06 with diagnoses of cerebral vascular accident (CVA) with resolving hemiplegia, hypertension, hypothyroidism, kyphoscoliosis, osteoarthritis and depression. The initial MDS, dated 2/5/06, documented the resident with modified cognitive impairment (some difficulty in new situations only). There were no falls documented for this assessment. The most current quarterly MDS, dated 4/25/06, documented the resident had fallen in the last 30 days and she needed limited assistance for transfers. The same MDS also documented her cognition as moderately impaired (decisions poor; cues/supervision required) which was a decline. The care plan, dated 5/9/06, documented, "Problem...Potential for injury from falls, related to: (L) sided weakness, poor safety awareness, history of falls... Approach... Identify factors that increase resident's potential for falls/injury: Is unaware of limitations. Encourage resident to request assistance. Utilize protective device: Tab alarm to wheelchair and pressure alarm to bed. Black mat at bedside. [One] 1/2 siderail for mobility...Occasionally confused, encourage use of call light and remind resident to wait for assistance. Non skid foot wear." All of these approaches had a revision date of 5/20/06. The following event reports were documented for resident #4: 2/2/06, 10:15 pm- "...Staff passing this room noted this resident was sitting on the floor. She	F 324	2. Any resident that has an injury or fall will have it reported through incident and accident reports, with a through investigation being completed to assure that each resident receives adequate supervision and assistive devices as needed to prevent falls. 3. In- service L.N. (Licensed Nurses) and IDT (Interdisciplinary team) for effective interventions for fall prevention and through investigation. 4. IDT (Interdisciplinary team) to audit post incidents and accidents for completeness of investigation and appropriate preventions to prevent reoccurrence. IDT will assess need for further interventions needed post fall. Administrator will monitor incidents and accidents for appropriate investigations, and use of assistive devices to aid in fall prevention as demonstrated by signing and dating. Results will be reported to CQI committee and will be followed until resolved. Date of Completion: 7/21/06	

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stated that she was getting up to take her pills. There was no injury noted. ...Interventions Implemented... An alarm has been placed on her bed and wheelchair. Staff has been inserviced regarding her alarms.
2/10/06, 4:00 am- "Staff responded to her bed alarm. The resident was sitting up on the edge of the bed. She slid to the floor gently. There was no injury noted. ...Interventions Implemented... This resident has a bed alarm. We will place a non-skid mat at her bedside."
2/18/06, 11:00 am- "No injury... This resident forgot that she cannot ambulate without assistance and attempted to self-transfer and sat down on the w/c [wheelchair] foot pedals, and then slid to the floor. ...Interventions Implemented... Staff inservicing done. Resident has tab alarms on her w/c and pressure alarms on her bed." There was no indication if alarm had sounded. What was the resident trying to do? When was the last time staff had assisted her?
3/11/06, 2:30 am- "No injury... Staff entered room, responding to bed alarm. This resident was sitting on the floor. She stated that she was going to the bathroom. CNA was in the room just a few minutes prior asking if she needed anything and the resident stated that she did not need anything. ...Interventions Implemented... We have added a tab alarm. We will cont. [continue] to enourage [sic] her to use her call-light and wait for assistance." The prior event report (2/18) indicated the resident already had a tab alarm.
3/12/06, 10:30 am- "Staff responding to alarms sounding, found this resident sitting on the floor. She stated that she was going to the bathroom. CNA had been in the room only a few minutes before and offered to assist her, but the resident had denied needing her for anything. Resident

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denies any injury and there were none noted with assessment by LN. ...Interventions Implemented... Her alarms have been changed out. Staff are monitoring her frequently. She has been placed on a toileting schedule."
3/20/06, 4:45 pm- "...heard a noise and entered the res. room. He found the resident sitting on the floor. She denied any injury and none were noted with assessment. ...Interventions Implemented... The alarm on her bed was changed out. This resident has been started on abx [antibiotics] for a UTI." There was no indication the facility had determined why her alarm did not sound or which alarm did not sound. There was no plan to monitor her alarms to ensure they were in working order.
4/20/06, 4:45 pm- "Staff responded to alarms sounding and found resident sitting the floor in front of her wheelchair. She stated that she had no injuries and none were noted, until a bruise was found 24 hours after her fall on her left buttock. ...Interventions Implemented... This resident has poor safety awareness. She has alarms in place and is checked on frequently. She had non-skid footwear on. We will continue to monitor her closely."
5/3/06, 11:45 am- "Staff responded to alarm sounding, found resident on the floor at her bedside. She had attempted to self transfer. She stated that she had no injury, and there were none found with assessment. ...Interventions Implemented... Resident education done, staff did frequent monitoring throughout the day. She has alarms on both her bed and wheelchair." Unable to determine what alarm was sounding. Was the resident getting out of her bed or her wheel chair? What did she need? When had staff last assisted her? The facility continues "education" to the

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resident as part of a fall prevention plan. The MDS, dated 4/25/06, documented the facility had assessed a cognitive decline for the resident.

In addition to the event reports the following documentation was in the resident's record:
A physician progress note, dated 2/24/06 documented, "I was asked to see her today because her lt [left] hand and fingers are all black and blue as though she has had some trauma. The occupational therapist that is working with her states that has occurred just since yesterday. She does not recall any injury to it but she apparently has some dysfunction of the lt hand. it has some 'athetoid movements' that she states just does on its own and certainly may have gotten in to the wheelchair at some time if she had some uncontrolled movements...Injury to lt hand resulting in ecchymoses and mild abrasions...Reassured that if we can protect that lt hand the discoloration, swelling, etc. will clear..."
On 4/21/06 another physician progress note documented, "...Today she demonstrates that she can grip pretty well with her lt hand. The last time I saw her she had fallen and bruised it quite badly and most of the discoloration has cleared..."
The DON was asked for the event report/investigation done for this incident. On 6/15/06 at 1:30 pm, she told the surveyor that no event report was documented.

A nurse progress note, dated 4/9/05 (5:00 am) documented, "Resident alert, able to make needs known- [illegible] pain meds effective- No c/o pain/discomfort, daughter in to visit at HS [night time]- while here resident caught left thumb in w/c staff removed from catch with difficulty- no bruising noted at time to thumb or hand but did

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discuss possibility of bruising with daughter due to ease of bruising on affected side- resident has been resting quietly in bed, up to toilet with assist, alarms in place to notify staff of attempts to self transfer."

The resident had two accidents which bruised her left hand which had been affected by her CVA. They had not put any prevention plans in place to protect her hand from further injury.

The resident was interviewed on 6/13/06 at 11:55 am. The resident was seated in her wheel chair in her room. She had an over bed table by her with glasses of juice and water on it. She had a quad cane on the right side of her next to the wheel chair. She was facing the bathroom door which was open. The surveyor asked to come in and speak with her. The resident agreed. The surveyor asked if she was able to get to the bathroom with the use of her cane independently. She put her finger to her lips and said, "Shh, I am not supposed to but I do if I have to." The surveyor said, "I guess they just don't want you to fall." She stated, "I know that, there is nothing wrong up here." (Was tapping her forehead with finger). She continued to say, "The girls just don't understand when I need to go I have to go. I can't wait. That is why I want to go now before lunch or they won't get me out of there when I need to use the bathroom. I told my doctor too, I will get up if I have to." The surveyor stayed with her until staff came in which was in just about 5 minutes. She was not receiving enough supervision to prevent falls.

2. Resident #1 was originally admitted to the facility on 1/12/06 and readmitted on 2/01/06 and

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F 324	Continued From page 75 5/02/06, with diagnoses of pneumonia, colitis with Clostridium difficile, and failure to thrive. The "Fall Risk Assessment," indicated the resident had been assessed as being at high risk for falls since the initial assessment on 1/12/06. A total score of 10 or above was considered to be an indicator of a high risk for falls. The resident had the following scores: 1. 1/12/06 - 22. The resident scored high due to intermittent confusion, previous falls in the past 3 months, was ambulatory but incontinent, had poor vision, took medications which could impair gait/balance, and had predisposing diseases. 2. 2/01/06 - 18. 3. 4/28/06 - 11. The resident continued to score high due to a history of falls, remained incontinent but ambulatory, had poor vision, required use of assistive devices and took medications which could impair gait/balance. 4. 5/02/06 - 18. The resident scored high due to being disoriented, a history of falls, remained incontinent but ambulatory, had poor vision, had balance problems, and continued to take medications which could cause an increased risk for falls. 5. 6/06/06 - 12. The MDS with the assessment date of 1/18/06 indicated the resident had a short term memory loss problem, required limited assistance of 1 person for transfer and walking and was not able to be tested for standing balance without physical help. The most recent MDS with the assessment date of 5/08/06, indicated the resident had fallen in the past 30 days and also in the past 31 to 180 day	F 324		

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period of time. The primary mode of locomotion was a wheelchair and the resident was not able to be tested for standing or sitting balance without physical help. The MDS indicated the resident had a problem with short term memory.

Review of the care plan conference summary dated 1/16/06, indicated that alarms had been placed on the bed and wheelchair. The care plan dated 5/29/06, indicated the resident had an alarm to the bed on 5/02/06, the date of the last readmission.

The "Event Management System," was reviewed and the following accidents had been investigated:

A. 4/28/06 at 3:20 am - The incident/accident investigation (I/A) indicated the resident was getting up to the toilet and fell sustaining an abrasion to the left elbow. The intervention implemented was to educate the resident to use the call light.
B. 4/28/06 at 4:35 am - The I/A indicated the resident was found on the floor wrapped in the bedding. The resident had stated he was trying to get some water. While being assisted up by staff, the resident hit his head on the dresser and sustained a skin tear. The intervention implemented was to get an MD order for a 1/2 rail to assist with safe bed mobility.

Review of the nursing notes indicated the resident had been complaining of stomach cramps since 4/11/06 and was on a titrating dose of antibiotic for the colitis. The following nursing notes indicated the resident was having increased loose stools on 4/28/06:

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a. 4/28/06 at 2:35 am - "Resident alert. No c/o [complaints of] stomach 'pain' but has had 3 loose stools. PRN [as needed] Imodium given as ordered. Temp. 98.1. PRN pain meds at HS [night time]."
b. 4/28/06 - "Condition Change Form...Resident had loose stools on PM [evening] shift. PRN med given. Continued to get up to toilet. At 0320 [3:20 am] resident fell in room. Only injury noted is an abrasion to left elbow..."
c. 4/28/06 - "Condition Change Form...At 0435 [4:35 am] resident turned over in bed and fell out of bed onto the floor. No injury until he hit his head on the dresser drawer handle when staff started to help him up..."
d. 4/28/06 at 1030 [10:30 am] - "Res [resident] B/P [blood pressure] [down] 88/56. HR [heart rate] [elevated] 117 - 120. SpO2 [oxygen saturation level] [down] 88.1% RA [room air]. [low] grade fever 100.1...diarrhea x 2...pt [patient] will be transported to VAMC [Veterans Administration Medical Center]..."

The resident, who was at high risk for falls and was having loose stools and subsequently had to be transferred to a hospital, had 2 falls over a 75 minute of time. The only interventions to prevent further falls included reminding the resident, who had a short term memory loss, to use the call light and to get a medical order for a side rail.

I/A's continued:

C. 5/02/06 at 8:46 pm - The I/A indicated the resident was found on the floor, next to the bed. The summary stated, "He had been restless earlier." According to the I/A, the interventions

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included getting an order for a side rail and obtaining a urine sample.

The nursing notes indicated the resident had returned to the facility from the hospital at 6:00 pm from the hospital. The resident was unable to sit upright and was on an air mattress. The "Condition Change Form," for 5/02/06 at 8:46 pm stated, "At 2046 [8:46 pm] this evening, resident rolled out of bed onto the floor. No apparent injury noted at this time...put siderails on bed to assist with bed mobility and to define edge of bed and put a mattress on floor at bedside..."

The resident had been assessed as being at high risk for falls upon admission on 5/02/06 with a score of 18, was unable to sit upright and was placed on an air mattress. There was no documentation about the type of air mattress and whether it could contribute to a resident sliding out of bed. Yet, the only initial intervention, according to the care plan, was to apply an alarm to the bed. Preventive interventions such as properly assessed side rails, a low bed and/or mat on the floor were not utilized or introduced until after a fall to the floor had already occurred.

D. 5/06/06 at 6:00 pm - The I/A indicated the resident was found on the floor next to his recliner. The interventions included instructing the resident to use the call light and to place an alarm in the chair.

The resident had a short term memory loss and an intervention included reminding him to use the call light. In addition, the resident was assessed at being a high risk for falls with a score of 18. When the resident was initially admitted to the

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F 324	Continued From page 79 facility on 1/12/06 with a fall risk assessment of 22, alarms were initially utilized on both the bed and chair. On this readmission, as the resident kept falling, the previous prevention tools were being recycled rather than using them initially. 3. Resident #10 was admitted to the facility on 1/22/06 and readmitted on 2/16/06, with diagnoses of Alzheimer dementia, anxiety disorder and chronic obstructive pulmonary disease. The "Fall Risk Assessment," indicated the resident had been assessed as being at high risk for falls since the initial assessment of 1/22/06. A total score of 10 or above was considered to be an indicator of a high risk for falls. The resident had the following scores: 1. 1/22/06 - 16. The resident scored high due to being disoriented, previous history of falls, poor vision, problems with gait/balance, taking medications which could cause increased risk for falls, and the resident had diseases which could contribute to falls. 2. 2/16/06 - 14. 3. 5/15/06 - 14. 4. 5/30/06 - 16. The admission MDS assessment for the assessment date of 1/28/06, indicated the resident had both long and short term memory problems, was moderately impaired with cognitive skills for daily decision making, required limited assist with transfers, and required 1 person assist for walking. The quarterly MDS for the assessment date of 5/13/06 indicated the resident still had both long	F 324		

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F 324	Continued From page 80 and short term memory problems, was moderately impaired with cognitive skills for daily decision making, required 1 person assist with transfers and walking, and had fallen in the past 31 to 180 days. The initial care plan dated 1/26/06, indicated the resident had stand-by assistance with transfers and ambulation and was receiving physical therapy to improve gait and balance. The care plan dated 6/05/06, indicated the approaches to prevent injury from falls included, encouraging the resident to request assistance, a pressure alarm to the bed, self releasing, alarming, seatbelt to the wheelchair, and evaluation for a toileting program. The "Event Management System," was reviewed and the following accidents had been investigated: A. 1/31/06 at 8:00 pm - The incident/accident investigation [I/A] indicated the resident was found sitting on the floor. The interventions indicated the resident had recently had a medication change and on 2/02/05 needed to be transferred to another facility for evaluation and further stabilizing of the medications. B. 5/04/06 at 7:30 pm - The I/A indicated alarms sounded and the resident was found sitting on the floor next to the wheelchair. The intervention was to place the resident on a 2 hour toileting plan. C. 5/27/06 at 12:00 pm - The I/A indicated alarms sounded and the resident was found sitting on the floor next to the wheelchair. The intervention stated, "Rx [treatment] begun for UTI [urinary tract infection]."	F 324		

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D. 5/30/06 at 4:00 pm - The I/A indicated the resident was trying to self transfer out of the wheelchair and ended up on the floor. The intervention stated, "MD has ordered tx [treatment] with abx [antibiotics] for a UTI."
E. 5/30/06 at 4:30 pm - The I/A indicated the resident was fidgeting in the wheelchair and attempting to self-ambulate. The resident fell out of the wheelchair and sustained a cut above the right eye. The intervention stated, "UA [urinalysis] was send [sic] to the lab. We are providing the rx by the MD."

The resident had established a pattern of falling out of the wheelchair since the first documented fall on 1/31/06. Yet for the last 3 falls, the intervention remained the same with the continued treatment of the UTI.

On 6/15/06 from 2:50 to 3:20 pm, the DON, administrator and nurse consultant were interviewed concerning the fall investigations and prevention for falls. The DON explained that the falls in May of 2006 were related to the resident complaining of increased need to urinate and that the resident was treated for a UTI. The DON stated, "she was continent of urine and was trying to get to the toilet." The DON concurred that more could be done to improve prevention as well as investigation.

4. Resident #8 was admitted to the facility on 11/1/05 with diagnoses of cerebral vascular accident (CVA) with right sided hemiplegia, diabetes and depression secondary to CVA.

The initial MDS, dated 11/17/05, did not indicate the resident had recent falls. A RAP did trigger for

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falls and the following was documented: "Rap triggered R/T [related to] recent CVA [decreased] mobility contribute to his decline and risk in safety issues. He is equipped [with] a safety alarm on his chair to alert staff of his status..." His most recent quarterly MDS, dated 5/1/06, documented he had fallen in the last 30 days and in the last 31-180 days. An additional fall risk assessment, dated 3/25/06, documented a score of 15 for fall risk. (Scores of 10 or above = high risk).

The resident's care plan, dated 6/13/06 documented, "Potential for injury from falls related to CVA w[ith]/R[ight] sided weakness, poor safety awareness." Approaches included, "Encourage resident to request assistance. Utilize protective device chair and bed alarms. 1/2 siderails up x 1 on door side of room to aid with bed mobility and transfers, not restrictive. Leaf symbol placed on door outside room, on w/c to visually identify resident as high risk for falls. All staff will monitor closely for attempts to transfer without assistance...Report any changes in function or behavior that increases risk for falls to charge nurse. Alarmed self release seat belt to alert staff of attempts at unassisted activity, not restrictive as resident is able to release."

Event reports were reviewed for resident #8 and contained the following documentation regarding non injury falls:
12/4/05, 10:00 am- "This resident was found sitting on the floor next to the toilet with his pants pulled partially down. His wheelchair was at the door of the bathroom. It appears he was self-transferring... Interventions implemented, We have placed a tab alarm to attach to his wheelchair. We have done resident education to

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have [resident #8] use his call-light and wait for assistance. He has agreed to do so."
(A nurse progress note, dated 12/5/05, documented, "...Res[ident] states via a translater that he transfers himself because he gets impatient waiting for staff to assist him because it takes too long to get to him and help him...")
12/13/05, 6:30 pm- "Resident self-transferred from wheelchair to bed. He slid off the edge of the bed to the floor...Interventions implemented, This resident is non-compliant with waiting for assistance. We are setting up a care conference with him and family. We have placed a self-releasing alarming seat belt on his wheelchair and have done education with him again regarding using his call-light and waiting for assistance. He states he understands and that he will use the call-light and wait for assistance. The facility had already tried this plan with the resident on 12/4/05. Nothing else was implemented to prevent another fall.
1/23/06, 3:40 pm- "Resident was found on the floor on his hands and knees. He was attempting to get back into the bed. He had taken off his bed alarm, and stated that he was going to the bathroom. Interventions implemented, Ongoing resident education is needed in this situation. We are also evaluating this resident for a toileting schedule." The facility was again providing education but not increasing supervision. The resident had been in the facility since 11/1/05. Please also refer to F315 as it relates to findings of inadequate assessment and voiding patterns which were not established for this resident.
1/24/06, 5:50 am- "Resident was found on the floor. He indicated he was trying to self-ambulate. He had his alarms disconnected. Interventions implemented, Staff education done to check on

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F 324	Continued From page 84 all alarms. Resident continued education regarding using call-lights and waiting for assistance. The facility did not interview staff working with the resident nor determine why the resident had been trying to ambulate independently. The report indicated he had the alarms disconnected but the documentation did not determined whether or not staff may have forgotten to connect the alarms or if he stated he did it himself. If in fact the resident was disconnecting his alarms it would not be affective for staff to check on the alarms as he could dismantle them whenever staff were not around. Increased supervision was not implemented. 3/25/06, 7:00 pm- "LN heard the res. turn on the call light in the bathroom. The CNA went right into the room and found the resident sitting on the floor. He had removed his tab alarm. Interventions implemented, Went with an interrepter [sic] to [resident #8] and discussed the need for him to use the call-light and wait for assistance. He acknowledged that he needs to wait for help. He also stated that he understands English very well." The facility had not determined what the resident's toileting needs were. He was not receiving adequate supervision to prevent falls. Also please refer to F323 as it relates to a side rail used for the resident which was hazardous.	F 324		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure that 1 of 3 sampled residents (#3) who received oxygen therapy was adequately monitored for titration of oxygen. The findings include: Resident #3 was admitted to the facility on 1/29/03 with diagnoses of profound impairment to both eyes, rectal prolapse and dementia with paranoid ideation. A physician progress note, dated 5/21/06, documented, "S[ubjective]: Her chief complaint is a change in level of consciousness noted just yesterday afternoon...Remarkable for very prominent, coarse rales and crackly sounds both on inspiration and expiration over the entire lt lung with the rt side being essentially clear...A[ssessment]: ...Lt sided pneumonitis...P[lan]: O2 will be offered to keep her SAT's [oxygen saturation levels] at 90% or above.	F 328	**F328 Special Needs** 1. Medical Record review for identified resident #3 to assure oxygen therapy is adequately monitored for titration of oxygen. 2. Residents with oxygen orders will be reviewed to assure proper treatment and care is provided by adequately monitoring titration of oxygen. 3. L.N. will be in serviced on checking oxygen saturation and proper documentation 4. D.O.N. or designee will audit compliance with oxygen orders, and proper documentation on random residents that receive oxygen. Results of audits will be reported to CQI committee and followed until issue resolved 5. Date Completed; 7/21/06	

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	135015	A. BUILDING _____ B. WING _____	06/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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5/21/06 (6:15 pm)- "Dr....in this a.m. to see resident...O2 @ 3 L/Min via N/C. Will cont[inue] to monitor."

The current recapitulation of physician orders for the month of June 2006 contained the following documentation: "O2 SAT check Q [every] shift and prn (dated 2/20/06)...O2 to keep SATS > to keep O2 @ 90% or above (dated 5/21/06)..." Treatment sheets were reviewed for April and May 2006. The resident had been receiving oxygen prior to 5/21/06. For the month of April SATS were not documented every shift on 17 of 30 days. (Liter flow was not documented) For the month of May SATS were not documented 13 of 31 days. On some days liter flow was documented for one shift only. On 5/30/06 the SAT level was documented on one shift only at 89%. There was no corresponding nurse progress note that assessed why her SAT level had fallen below the 90% or what staff did to correct the problem.

The resident was observed on 6/12/06 at 12:20 pm and 2:40 pm laying on her back in bed. She had a specialized air exchange mattress on her bed. Her eyes were closed and she had oxygen by nasal canula (N/C) running at 2 liters per minute. Again on 6/13 at 6:50 am and 6/14 at 8:00 am the resident was receiving oxygen at 2 L per minute by N/C. This was the case for all observations up to 6/15/06.

While reviewing resident #3's chart with the surveyor, on 6/15/06 at 1:30 pm, the DON agreed that there was not consistent documentation to adequately assess the use of the oxygen.

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F 328	Continued From page 87 The facility did not adequately monitor resident #3 for the use of her oxygen. Oxygen SATs in relation to liter flow were not being documented consistently. It was not consistently documented what symptoms were exhibited by the resident which required changes in the O2 liter flow levels.	F 328	**F364 Food** 1. Identified resident #1 will receive breakfast meats as part of routine breakfast meal when on menu for General diets. 2. New cycle of menus started that provide a variety of food items and that serve mech. altered diets breakfast meat when it is on the menu. 3. Menus reviewed by R.D. for redundancy of food items prior to implementation. Menus will be reviewed by R.D. to assure breakfast meats are also available for mech. altered diets prior to implementation of menus. 4. Dietary Manager will interview residents to assure they are satisfied with variety of food offered. Interview results will be reported to CQI committee, any issue will be followed until resolved. 5.Date Completed: 7/21/06	
F 364 SS=C	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on review of menus, observations, resident interviews, and staff interviews, it was determined the facility did not ensure that residents were served a variety of meat and that residents on a mechanical diet received breakfast meals which were equivalent to the regular diets served at breakfast. This affected 1 of 10 sampled residents (#1) on a mechanical diet, 9 of 10 (#1, 2, 4, 5, 6, 7, 8, 9, 10) sampled residents who ate food prepared at the facility, and all other residents who ate in the dining room. The findings include: 1. Resident #1 was observed eating breakfast in the independent dining room on 6/13/06 at 8:10 am. The resident was observed eating hot cereal, french toast and a hard boiled egg. The resident sitting next to resident #1 was observed eating	F 364		

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the same entrees except that resident had a slice of bacon and no egg. Four other residents in the independent dining room were observed being served bacon, hot cereal and french toast and did not have a hard boiled egg.

The recapitulated physician orders for June of 2006, indicated the resident #1 was on a mechanical soft diet.

The menus and spreadsheets for the past 5 weeks were reviewed. The mechanical soft entrees were compared to the regular diets. On the following weeks, the mechanical soft breakfast entree did not include meat which was provided to the regular diets:

a. Week 1 - Sunday, 6/11/06 - The regular diet entree included 1 slice of bacon with the omelet, biscuit, and oatmeal. The mechanical soft entree had no bacon slice. All other entrees were the same.
b. Week 1 - Tuesday, 6/13/06 - The regular diet entree included 1 slice of bacon with the french toast and oatmeal. The mechanical soft entrees included a hard boiled egg, oatmeal and french toast.
c. Week 1 - Wednesday, 6/14/06 - The regular diet entree included cream of wheat, egg sausage bake and buttered toast. The mechanical soft entrees included cream of wheat, scrambled eggs and buttered toast. The egg sausage bake had not been included in the mechanical diet.
d. Week 1 - Saturday, 6/17/06 - The regular diet entrees included bacon with pancakes and hot cereal. The mechanical soft entrees included scrambled eggs, pancakes and hot cereal.

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F 364	Continued From page 89 On Monday of week 1, the breakfast entrees for the regular and mechanical soft diets did not include a meat. On Thursday of week 1, the regular entree included sausage gravy and the mechanical soft entree included ground sausage gravy. On Friday of week 1 the regular entree included ham and cheese and the mechanical soft included ground ham and cheese. The spread sheet reflected that the facility was capable of providing the same or equivalent entree for the mechanical soft diet. e. Week 2 - Monday, 6/5/06 - The regular diet entrees included hot cereal, 2 hard boiled eggs and 1 slice of bacon. The mechanical diet entrees were the same except they did not receive the slice of bacon. f. Week 2 - Friday, 5/9/06 - The regular diet entrees included hot cereal, scrambled eggs, 1 slice of bacon and buttered toast. The mechanical soft entrees included the same except they did not receive the slice of bacon. g. Week 3 (5/28 - 6/03/06)- On Sunday and Thursday the regular diet entrees included a slice of bacon. The mechanical soft included the same entrees except the bacon. h. Week 4 (also referred to as "cycle B week 1," 5/21 - 5/27/06) - On Sunday, the regular diet entree included a slice of bacon and the mechanical soft diet did not include a slice of bacon or a substitute. i. Week 4 - On Tuesday, the regular entree included 2 sausage patties and 2 ounces of sausage gravy with a biscuit. The mechanical soft diet did not include any ground sausage or ground sausage gravy. In lieu of ground sausage	F 364		